Alaska Open Imaging Center, LLC

Patient Name:____

Patient Phone: Home:________________ Work/Cell:________________ DOB:____________

Exam Date:________________________ Exam Time:______________________________

Anchorage		
6911 DeBarr Road		❑ Open MRI
Anchorage, Alaska 99504		❑ CT
		❑ Ultrasound
		❑ PET/CT
Phone	907-330-1220	❑ F-18 PET Bone Scan
Fax	907-330-1222	

Soldotna		
35670 Kenai Spur Hwy.		❑ Open MRI
Suite 104		❑ Bone Density
Soldotna, Alaska 99669		❑ X-Ray
Phone	907-260-6501	
Fax	907-260-6502	

Wasilla		
1751 East Gardner Way		❑ High-field MRI
Suite B		❑ CT
Wasilla, Alaska 99654		❑ PET
		❑ Ultrasound
		❑ Nuclear Medicine
Phone	907-357-1220	❑ Mammography
Fax	907-357-1222	❑ Bone Density
		❑ X-Ray

Exam Requested:____

DX Codes:________________________Creatinine Level (CT/MRI):______________Date Drawn:_________________

Symptoms:____

____

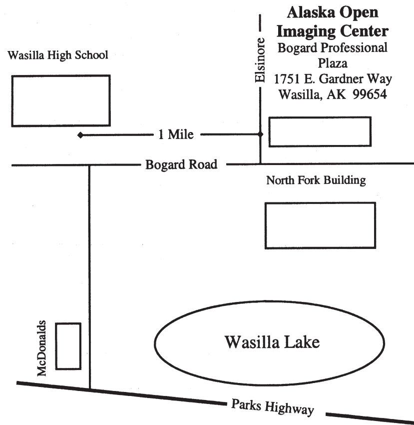
❑ Contrast as necessary ❑ Weight Bearing ❑ Transvaginal Ultrasound as necessary

______________________________________ ________________ ________________

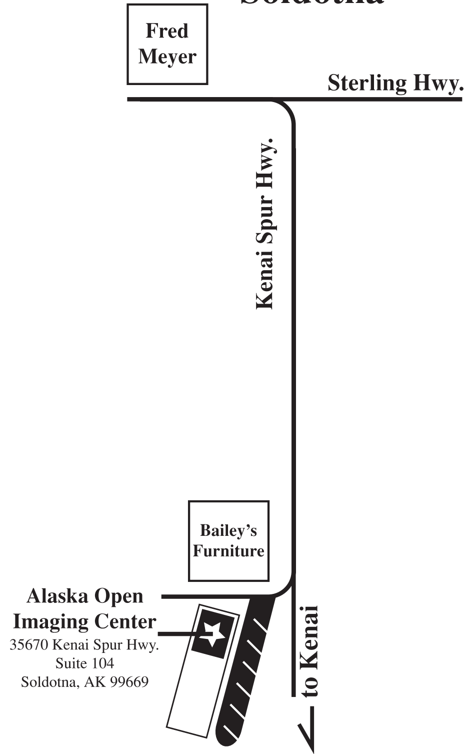
Referring Physician Signature | Physician Phone | Physician Fax

10/2010 ***Patient to return with ❑ Film ❑ CD***

Wasilla



Soldotna



Anchorage