631-444-5544
zprad.com

PATIENTS: CALL TO MAKE AN APPOINTMENT TAKE A CELL PHONE PHOTO OF THIS FORM AND TEXT OR EMAIL IT TO RX@ZPRAD.COM

Physician *Letter of Medical Necessity*

Please be advised that ______________________ ______________________ is presently
Patient Name Date of Birth

being treated under my care. I find the test indicated below to be medically necessary.

Clinical Indications/Signs/Symptoms:

____

____

______________________________ ICD-10: ______________________

Richard J. Bebirian, D.O., P.C.

1 Carman Gate • Massapequa, NY 11758

Tel: 516.795.4343 • Fax: 516.795.4115

Signature (required): ______________________________

RADIOLOGICAL IMAGING REFERRAL

☐ **MRI** ☐ **MRA** Body Region ______________________
- ○ With & Without Contrast ○ No Contrast
- ○ 3T Wide-Bore ○ 1.5T Wide-Bore ○ Either 3T or 1.5T Wide-Bore

☐ **CT** ☐ **CTA** Body Region ______________________
- ○ With & Without Contrast ○ Only With Contrast ○ No Contrast

☐ **Ultrasound** Body Region ______________________

☐ **PET/CT** ○ Routine Oncologic ○ Metabolic Brain ○ Other:

☐ **Nuclear Medicine** Body Region ______________________

☐ **Biopsy** Body Region ______________________

☐ **X-Ray** Body Region ______________________ Specify: ○ Right ○ Left ○ Bilateral

Women's Imaging

☐ **Mammogram-Screening With 3D Breast Tomosynthesis**

☐ **Mammogram-Screening**
- ○ Add ultrasound if indicated based on mammogram results
- ○ Add diagnostic 3D mammogram if indicated from screening mammogram
- ○ Add diagnostic mammogram if indicated from screening mammogram

☐ **Breast Ultrasound** ○ Bilateral ○ Right ○ Left

☐ **DXA Bone Density**

☐ **Breast Biopsy** ○ Stereotactic ○ Ultrasound-guided ○ MRI-guided

☐ **Other** ______________________

ZWANGER-PESIRI RADIOLOGY