ZWANGER-PESIRI RADIOLOGY
(631) 444-5544
zprad.com

Gastroenterology

Physician *Letter of Medical Necessity*

Please be advised that _____ (Patient Name) _____ (Date of Birth) is presently being treated under my care. I find the test indicated below to be medically necessary.

Clinical Indications/Signs/Symptoms

_____

_____

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Signature (Required):

GASTROINTESTINAL IMAGING

☐ **MRI** ☐ wo/w contrast ☐ no contrast

☐ With I.V. Sedation

- ☐ Abdomen
  - ☐ MRCP
  - ☐ Liver
  - ☐ Pancreas
  - ☐ Other
- ☐ Pelvis
  - ☐ Colorectal cancer staging
  - ☐ Anorectal fistula
  - ☐ Dynamic Pelvis / Defecography
  - ☐ Other
- ☐ Abdomen + Pelvis / Enterography

☐ **CT** ☐ With 2D and 3D Reformatting

☐ wo/w contrast ☐ no Contrast

- ☐ Abdomen
- ☐ Abdomen/Pelvis
- ☐ Abdomen/Pelvis/Chest
- ☐ CT Enterography
- ☐ Other

☐ **Ultrasound**

- ☐ Abdomen
- ☐ Pelvis
- ☐ Other

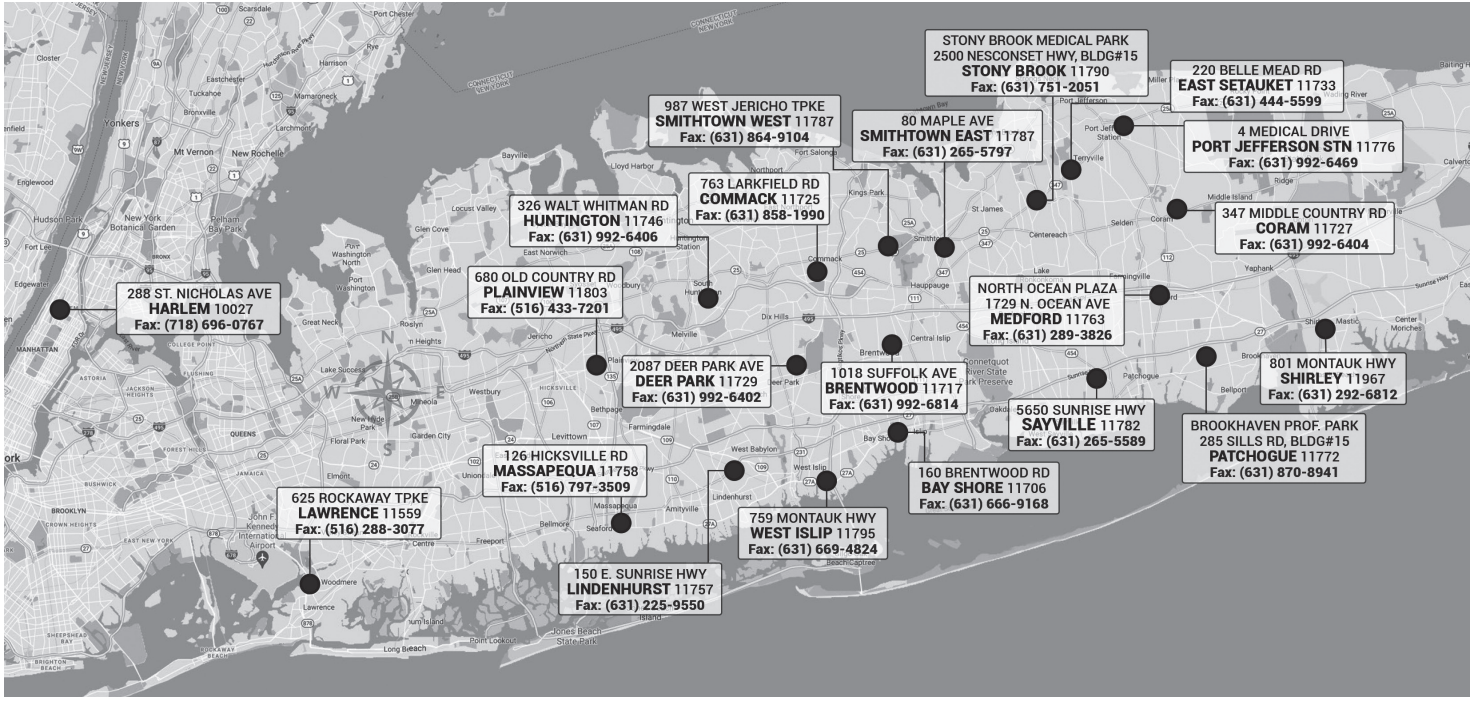
☐ **Nuclear Medicine**

- ☐ HIDA Scan
- ☐ CCK HIDA
- ☐ Gastric Emptying
- ☐ Other

☐ **Fluoroscopy**

- ☐ Esophagram
- ☐ Upper GI Series
- ☐ Upper GI & Small Bowel Series
- ☐ Small Bowel Series
- ☐ Lap Band
- ☐ Other

☐ **Other**



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