



PATIENT LAST NAME: _____ PATIENT FULL FIRST NAME: _____ TODAY'S DATE: ____/____/____ DATE OF BIRTH: ____/____/____

CLINICAL INDICATIONS/SIGNS/SYMPTOMS (NOT RULE/OUT): _____ ICD-10: _____

PHYSICIAN SIGNATURE (REQUIRED): **Anders J. Cohen, MD** 240 Willoughby St, Brooklyn, NY 11201
T: (516) 619-6996 F: (877) 462-3678

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

■ MRI

3T Wide-Bore 1.5T Wide-Bore 1.2 Open-Sided
 Either 3T or 1.5T Wide-Bore

With & without contrast No contrast

With I.V. sedation

| | |
|--|---|
| <p>Neuro/ENT/Spine</p> <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> IAC <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Sacrum/coccyx <input type="checkbox"/> CSF Flow <input type="checkbox"/> DTI <input type="checkbox"/> Perfusion <input type="checkbox"/> MR spectroscopy <input type="checkbox"/> TMJ <input type="checkbox"/> Soft tissue neck/parotid | <p>Chest & Body</p> <input type="checkbox"/> Chest <input type="checkbox"/> Breast MRI <input type="checkbox"/> Cardiac MRI <input type="checkbox"/> Function <input type="checkbox"/> Viability <input type="checkbox"/> Mediastinum <input type="checkbox"/> Brachial plexus <input type="checkbox"/> Scapula <input type="checkbox"/> Sternum <input type="checkbox"/> Thoracic outlet <input type="checkbox"/> Abdomen Specify _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> Dynamic pelvis/ MR defogram <input type="checkbox"/> Prostate <input type="checkbox"/> Enterography <input type="checkbox"/> MRCP <input type="checkbox"/> Rectal MRI |
| <p>MRA</p> <input type="checkbox"/> Carotid MRA <input type="checkbox"/> Intracran/circle of Willis <input type="checkbox"/> Intracran/MR venogram <input type="checkbox"/> MR venogram Specify _____ <input type="checkbox"/> NOVA <input type="checkbox"/> Carotid <input type="checkbox"/> Aortic arch <input type="checkbox"/> Abdominal aorta only <input type="checkbox"/> Renal arteries <input type="checkbox"/> Mesenteric arteries <input type="checkbox"/> Aorta/lower extremities | <input type="checkbox"/> Other _____ |

■ CT

With Contrast Without Contrast With & Without Contrast
 Oral Contrast Only IV Contrast Only Oral & IV Contrast

| | |
|---|--|
| <p>CT Angiography</p> <input type="checkbox"/> Coronary artery CTA with calcium scoring (needs contrast) <input type="checkbox"/> Chest CTA/PE <input type="checkbox"/> Calcium scoring only <input type="checkbox"/> CT angiogram (needs contrast) <input type="checkbox"/> Intracranial <input type="checkbox"/> Carotid <input type="checkbox"/> Aortic arch/thoracic aorta <input type="checkbox"/> Renal <input type="checkbox"/> Lower extremity run off | <p>Spine</p> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic Specify levels _____ <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/coccyx |
| <p>Neuro/ENT</p> <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal bones <input type="checkbox"/> Paranasal sinuses <input type="checkbox"/> Soft tissues neck | <p>Body</p> <input type="checkbox"/> Stone hunt <input type="checkbox"/> Hematuria <input type="checkbox"/> Chest only <input type="checkbox"/> Soft tissues neck/chest/abdomen/pelvis <input type="checkbox"/> Soft tissues neck only <input type="checkbox"/> Chest/abdomen/pelvis <input type="checkbox"/> Abdomen/pelvis <input type="checkbox"/> Enterography <input type="checkbox"/> Abdomen only <input type="checkbox"/> Pelvis only <input type="checkbox"/> Triple phase liver |
| <p>Musculoskeletal</p> <input type="checkbox"/> Joint Specify _____ <input type="checkbox"/> Extremity Specify _____ <input type="checkbox"/> Scanogram | <input type="checkbox"/> Other _____ |

■ DXA Bone Density

■ Echocardiogram

■ MRI/PET

Add MR intravenous contrast if needed
PET Only Auth#: _____

78608 Brain PET
 78812 Top of head to mid thigh
 78813 Top of head to toes (melanoma protocol)

With additional MRI Body region: _____
MRI Auth#: _____

■ PET/CT

Add CT intravenous contrast if needed
PET/CT Auth#: _____

78608 Brain PET
 78815 Base of skull to mid thigh
 78816 Top of head to toes (melanoma protocol)

Other: _____

■ Digital X-RAY

| | | | | | | | | | | | |
|---------------------------------------|----------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|--------------------------------|----------------------------------|--------------------------------|---------------------------------------|--------------------------------|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Skull | <input type="checkbox"/> C spine | <input type="checkbox"/> Chest | <input type="checkbox"/> Bone age | <input type="checkbox"/> Shoulder | <input type="checkbox"/> R O L | <input type="checkbox"/> Wrist | <input type="checkbox"/> R O L | <input type="checkbox"/> Femur | <input type="checkbox"/> R O L | <input type="checkbox"/> Foot | <input type="checkbox"/> R O L |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> T spine | <input type="checkbox"/> F/U abdomen | <input type="checkbox"/> Ribs | <input type="checkbox"/> Humerus | <input type="checkbox"/> R O L | <input type="checkbox"/> Hand | <input type="checkbox"/> R O L | <input type="checkbox"/> Knee | <input type="checkbox"/> R O L | <input type="checkbox"/> Toes | <input type="checkbox"/> R O L |
| <input type="checkbox"/> Facial bones | <input type="checkbox"/> L spine | <input type="checkbox"/> KUB abdomen | | <input type="checkbox"/> Elbow | <input type="checkbox"/> R O L | <input type="checkbox"/> Fingers | <input type="checkbox"/> R O L | <input type="checkbox"/> Tibia/fibula | <input type="checkbox"/> R O L | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Nasal bones | <input type="checkbox"/> Sacrum | <input type="checkbox"/> Pelvis | | <input type="checkbox"/> Forearm | <input type="checkbox"/> R O L | <input type="checkbox"/> Hips | <input type="checkbox"/> R O L | <input type="checkbox"/> Ankle | <input type="checkbox"/> R O L | | |



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