



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)

Maury Harris, MD

251-15 Union Turnpike, Bellerose, NY 11426 T:(516) 358-2121 • F:(516) 358-3190
66-86 Fresh Pond Rd, Ridgewood, NY 11385 T:(718)576-3607 • F:(347) 987-3565

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>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
<p>Orthopedic</p> <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Upper arm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Finger <input type="checkbox"/> R <input type="checkbox"/> L Specify _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Thigh <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lower leg <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toe <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Cartilage mapping <input type="checkbox"/> MR arthrogram Specify _____	<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 <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 <input type="checkbox"/> Other _____
<p>Musculoskeletal</p> <input type="checkbox"/> Joint Specify _____ <input type="checkbox"/> Extremity Specify _____ <input type="checkbox"/> Scanogram	

■ Ultrasound

<input type="checkbox"/> Breast <input type="checkbox"/> Bilateral <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotal/testicular <input type="checkbox"/> Transrectal prostate <input type="checkbox"/> Pelvis (GYN) <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <input type="checkbox"/> Transabdominal / Transvaginal <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> Obstetrical <input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta only <input type="checkbox"/> Retroperitoneum (Renal/Bladder) <input type="checkbox"/> Other _____	<p>Vascular</p> <input type="checkbox"/> Carotid doppler <input type="checkbox"/> Venous doppler <input type="checkbox"/> Lower extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Arterial doppler <input type="checkbox"/> Lower extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Renal arterial doppler
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■ Digital X-RAY

<input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Facial bones <input type="checkbox"/> Nasal bones <input type="checkbox"/> Sinuses <input type="checkbox"/> C spine <input type="checkbox"/> T spine <input type="checkbox"/> L spine <input type="checkbox"/> Sacrum <input type="checkbox"/> Chest <input type="checkbox"/> F/U abdomen <input type="checkbox"/> KUB abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Bone age <input type="checkbox"/> Ribs <input type="checkbox"/> Other _____	<input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Fingers <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hips <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tibia/fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toes <input type="checkbox"/> R <input type="checkbox"/> L
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APPOINTMENT or go to
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TOWN	ADDRESS	TRANSIT	FAX NUMBER
MANHATTAN HARLEM	324 W125th St, 10027	M3, M10, M100, M101, M60, BX15	(718) 696-0767
BRONX PARKCHESTER	1888 Westchester Ave, 10472	Q44, BX4, BX4A, BX36, BX39	(718) 696-0193
BROOKLYN COBBLE HILL	205 Smith Street, 11201	B57	(718) 684-7425
BROOKLYN CROWN HTS	1128 Eastern Pkwy, 11213	B14, B17, B46	(718) 684-7438
QUEENS BAYSIDE	213-02 Northern Blvd, 11361	Q12, Q13, Q27, Q31, QM3, n20, n20G	(718) 684-7423
QUEENS ELMHURST	88-12 Queens Blvd, 11373	Q59, Q60	(718) 684-7427
QUEENS LAURELTON	231-35 Merrick Blvd, 11413	Q5	(718) 684-7421
QUEENS OZONE PARK	102-34 Atlantic Ave, 11416	Q24	(718) 684-7429

