

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): _____
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 2835 Middle Country Rd, Lake Grove, NY 11755

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

Neuro/ENT/Spine <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	MRA <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
Orthopedic <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 _____	Chest & Body <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"/> Clavicle/sc joint <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

CT Angiography <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	Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic Specify levels _____ <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/coccyx
Neuro/ENT <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal bones <input type="checkbox"/> Paranasal sinuses <input type="checkbox"/> Soft tissues neck	Body <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 _____
Musculoskeletal <input type="checkbox"/> Joint Specify _____ <input type="checkbox"/> Extremity Specify _____ <input type="checkbox"/> Scanogram	

■ Mammography

Please schedule breast sonogram appointment if needed based on the mammogram.

Screening With 3D Tomosynthesis (no palpable finding or symptoms)
 Bilateral Right Left

Screening (no palpable finding or symptoms)
 Bilateral Right Left

Diagnostic With 3D Tomosynthesis-Must select reason(s)
 Bilateral Right Left

Diagnostic - Must select reason(s)
 Bilateral Right Left

Reasons:
 Additional diagnostic views
 Short term follow up
 New lump, mass or thickening
 Old lump or mass increased in size
 New nipple discharge
 New inverted nipple
 Skin changes (dimpling, redness or abnormal increase in breast size)
 Lymphadenopathy
 Current use of Tamoxifen, Femara or Arimidex

■ Nuclear Medicine

<input type="checkbox"/> Bone scan <input type="checkbox"/> Add SPECT if needed <input type="checkbox"/> Whole body <input type="checkbox"/> 3 phase Region _____ <input type="checkbox"/> Cardiac <input type="checkbox"/> Myocardial perfusion stress study <input type="checkbox"/> With treadmill/exercise <input type="checkbox"/> With pharm. agent <input type="checkbox"/> MUGA (gated blood pool)	<input type="checkbox"/> Thyroid <input type="checkbox"/> Uptake & scan <input type="checkbox"/> I-131 treatment Dose _____ <input type="checkbox"/> HIDA/DISIDA <input type="checkbox"/> With cholecystokinin <input type="checkbox"/> Renal <input type="checkbox"/> With lasix washout <input type="checkbox"/> DTPA <input type="checkbox"/> Parathyroid <input type="checkbox"/> Gastric emptying <input type="checkbox"/> Other _____
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■ 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 _____	Vascular <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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■ 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: _____

■ Interventional Biopsy

Thyroid Lung Liver
 US Breast FNA Specify Region _____
 US Core Biopsy (includes post procedure mammo) Specify Region _____
 Stereotactic Biopsy (includes post procedure mammo) Specify Region _____
 Perform targeted US first, if lesion identified, biopsy under US
 MRI Breast Biopsy 1 Specify Region _____
 Perform targeted US first, if lesion identified, biopsy under US
 Other _____

■ Echocardiogram

■ DXA Bone Density

■ Fluoroscopy

Lap band
 Hysterosalpingogram
 Other: _____

■ Digital X-RAY

Patients can print registration forms online

<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 <input type="checkbox"/> L	<input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> 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 <input type="checkbox"/> L	<input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Toes <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Facial bones	<input type="checkbox"/> L spine	<input type="checkbox"/> KUB abdomen		<input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Fingers <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Tibia/fibula <input type="checkbox"/> R <input type="checkbox"/> 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 <input type="checkbox"/> L	<input type="checkbox"/> Hips <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L	

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ABDOMEN/PELVIS CT CONTRAST INFORMATION

NO ORAL NO IV	NO ORAL PRE + POST IV	NO ORAL POST IV ONLY	YES ORAL PRE + POST IV	YES ORAL NO IV	YES ORAL POST IV ONLY	YES ORAL PRE + POST IV
•Abdominal+Pelvis No contrast	•Abdomen Pre+Post •Pelvis Pre+Post	•CTA •Abdomen •Abdomen+Pelvis	•Abdomen Pre + Post	•Abdomen + Pelvis No IV Contrast	•Abdomen + Pelvis Post Contrast	•Abdomen Pre + Post •Pelvis Post
74176	74178	74174	74170	74176	74177	74178
•For Stone Hunt Study Only	•Urogram •Hematuria CTA ABDOMINAL AORTA TO EVALUATE STENT GRAFT 74175	75635-run off •Aortic Aneurysm •Aortic Aneurysm With Runoff	•Triple Phase Liver •Pancreas Study •Kidney Tumor •Adrenal Study	•Pain •Appendicitis •Diverticulitis	•Bloating •Diffuse Abdominal Pain •Enterography •Lymphoma	•Oncology Follow Up •Breast Cancer •Cervical Cancer •Colon Cancer

MRI BODY & BODY VASCULAR

BODY PART	PROCEDURE TO PRE-CERT	REASON FOR EXAM	CPT
Abdomen	MRI Abdomen Non Contrast	MRCP Hemachromatosis	74181
Abdomen	MRI Abdomen Pre and Post IV Contrast	Kidneys Liver Mass Adrenals Pancreas	74183
Brachial Plexus	MRI Chest Non Contrast	Brachial Plexus Neuropathy	71550
Chest Mediastinum	MRI Chest Pre and Post IV Contrast	Infection Mass Metastatic Disease Thoracic Outlet Syndrome	71552
Breast	MRI Breast Pre and Post IV Contrast	Breast Cancer BRCA 1/2 Positive Family History of Breast Cancer	77059
Breast	MRI Breast Non IV Contrast	Implant Rupture	77059
Cardiac	MRI Heart Pre and Post IV Contrast	Myocardial Perfusion EF Myocardial Infarction	75561
Pelvis - Female (GYN)	MRI Pelvis Pre and Post IV Contrast	Adenomyosis Endometriomas Menses Problems Pelvic Pain Uterine Anomalies Adnexal Mass Endometrial CA Known Fibroids Ovarian CA Ovarian Cysts Pre-embolization work-up Uterine Artery Embolus Rectocele Cystocele	72197
Pelvis - Male	MRI Pelvis Pre and Post IV Contrast	Prostate Rectal Staging	72197

ZP RAD

324W 125TH STREET HARLEM 10027 Fax (718) 696-0767

1390 HEMPSTEAD TPKE ELMONT 11003 Fax (516) 798-8354

907 NORTHERN BLVD GREAT NECK 11021 Fax (516) 288-3075

1888 WESTCHESTER AVE PARKCHESTER 10472 Fax (718) 696-0193

205 SMITH STREET COBBLE HILL 11201 Fax (718) 684-7425

1128 EASTERN PKWY CROWN HEIGHTS 11213 Fax (718) 684-7438

102-34 ATLANTIC AVE OZONE PARK 11416 Fax (718) 684-7429

231-35 MERRICK BLVD LAURELTON 11413 Fax (718) 684-7421

272 NORTH BROADWAY HICKSVILLE 11801 Fax (516) 681-0302

88-12 QUEENS BLVD ELMHURST 11373 Fax (718) 684-7427

625 ROCKAWAY TPKE LAWRENCE 11559 Fax (516) 288-3077

443 SUNRISE HWY LYNBROOK 11563 Fax (516) 933-0745

2087 DEER PARK AVE DEER PARK 11729 Fax (631) 992-6402

326 WALT WHITMAN RD HUNTINGTON 11746 Fax (631) 992-6406

680 OLD COUNTRY RD PLAINVIEW 11803 Fax (516) 433-7201

2012 SUNRISE HWY MERRICK 11566 Fax (516) 868-9308

375 W. SUNRISE HWY FREEPORT 11520 Fax (516) 544-5004

987 WEST JERICO TPKE SMITHTOWN WEST 11787 Fax (631) 864-9104

763 LARKFIELD RD COMMACK 11725 Fax (631) 858-1990

126 HICKSVILLE RD MASSAPEQUA 11758 Fax (516) 797-3509

3235 HEMPSTEAD TPKE LEVITTOWN 11756 Fax (516) 544-5002

80 MAPLE AVE SMITHTOWN EAST 11787 Fax (631) 265-5797

STONY BROOK MEDICAL PARK 2500 NESCONSET HWY, BLDG#15 STONY BROOK 11790 Fax (631) 751-2051

160 BRENTWOOD RD BAY SHORE 11706 Fax (631) 666-9168

759 MONTAUK HWY WEST ISLIP 11795 Fax (631) 669-4824

150 E. SUNRISE HWY LINDENHURST 11757 Fax (631) 225-9550

5650 SUNRISE HWY SAYVILLE 11782 Fax (631) 265-5589

4 MEDICAL DRIVE PORT JEFFERSON STN 11776 Fax (631) 992-6469

220 BELLE MEAD RD EAST SETAUKET 11733 Fax (631) 444-5599

347 MIDDLE COUNTRY RD CORAM 11727 Fax (631) 992-6404

801 MONTAUK HWY SHIRLEY 11967 Fax (631) 292-6812

NORTH OCEAN PLAZA 1729 N. OCEAN AVE MEDFORD 11763 Fax (631) 289-3826

BROOKHAVEN PROF. PARK 285 SILLS RD, BLDG#15 PATCHOGUE 11772 Fax (631) 870-8941

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