



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

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

1440 York Avenue, Suite P5, New York, N.Y. 10075
T: (212) 988-5200 F: (212) 988-5201
PHYSICIAN SIGNATURE (REQUIRED): _____

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

Brain
 Orbits
 Pituitary
 IAC
 Cervical spine
 Thoracic spine
 Lumbar spine
 Sacrum/coccyx
 CSF Flow
 DTI
 Perfusion
 MR spectroscopy
 TMJ
 Soft tissue neck/parotid

MRA

Carotid MRA
 Intracran/circle of Willis
 Intracran/MR venogram
 MR venogram
Specify _____

NOVA
 Carotid
 Aortic arch
 Abdominal aorta only
 Renal arteries
 Mesenteric arteries
 Aorta/lower extremities

Chest & Body

Chest
 Breast MRI
 Cardiac MRI
 Function Viability
 Mediastinum
 Brachial plexus
 Scapula
 Sternum
 Thoracic outlet
 Abdomen
Specify _____

Pelvis
 Hip
 Thigh
 Knee
 Lower leg
 Ankle
 Foot
 Toe
 Cartilage mapping
 MR arthrogram
Specify _____

Other _____

■ CT

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

CT Angiography

Coronary artery CTA with calcium scoring (needs contrast)
 Chest CTA/PE
 Calcium scoring only
 CT angiogram (needs contrast)
 Intracranial
 Carotid
 Aortic arch/thoracic aorta
 Renal
 Lower extremity run off

Spine

Cervical
 Thoracic
Specify levels _____

Lumbar
 Sacrum/coccyx

Body

Stone hunt
 Hematuria
 Chest only
 Soft tissues neck/chest/abdomen/pelvis
 Soft tissues neck only
 Chest/abdomen/pelvis
 Abdomen/pelvis
 Enterography
 Abdomen only
 Pelvis only
 Triple phase liver
 Other _____

Neuro/ENT

Brain
 Orbits
 Temporal bones
 Paranasal sinuses
 Soft tissues neck

Musculoskeletal

Joint
Specify _____
 Extremity
Specify _____
 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

■ DXA Bone Density

■ Ultrasound

Breast
 Bilateral R L
 Thyroid
 Scrotal/testicular
 Transrectal prostate
 Pelvis (GYN)
 Transabdominal
 Transvaginal
 Transabdominal / Transvaginal
 Hysterosonogram
 Obstetrical
 Abdomen
 Aorta only
 Retroperitoneum (Renal/Bladder)
 Other _____

Vascular

Carotid doppler
 Venous doppler
 Lower extremity
 R L Bilateral
 Upper extremity
 R L Bilateral
 Arterial doppler
 Lower extremity
 R L Bilateral
 Upper extremity
 R L Bilateral
 Renal arterial doppler

■ 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#: _____

■ Nuclear Medicine

Bone scan
 Add SPECT if needed
 Whole body
 3 phase
Region _____

Cardiac
 Myocardial perfusion stress study
 With treadmill/exercise
 With pharm. agent
 MUGA (gated blood pool)

Thyroid
 Uptake & scan
 I-131 treatment
Dose _____

HIDA/DISIDA
 With cholecystokinin
 Renal
 With lasix washout
 DTPA
 Parathyroid
 Gastric emptying
 Other _____

■ Echocardiogram

■ 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 _____

■ Digital X-RAY

Skull C spine Chest Bone age Shoulder R L Wrist R L Femur R L Foot R L

Orbits T spine F/U abdomen Ribs Humerus R L Hand R L Knee R L Toes R L

Facial bones L spine KUB abdomen Elbow R L Fingers R L Tibia/fibula R L Ankle R L Other: _____

Nasal bones Sacrum Pelvis Forearm R L Hips R L Ankle R L



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SCAN TO SCHEDULE YOUR
APPOINTMENT or go to
schedule.zprad.com

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|----------------------|-----------------------------|------------------------------------|----------------|
| 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 |
| CROWN HTS | 1128 Eastern Pkwy, 11213 | B14, B17, B46 | (718) 684-7438 |
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