

		/ /	/ /
PATIENT LAST NAME	PATIENT FULL FIRST NAME	<b>TODAY'S DATE</b>	
<b>CLINICAL INDICATIONS/SIGNS/SYMPTOMS (NOT RULE/OUT):</b> _____		<b>ICD-10:</b> _____	

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**PHYSICIAN SIGNATURE (REQUIRED)**  Aslam A. Jivani, MD  Barbara Napoli



**PATIENTS: 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><b>Neuro/ENT/Spine</b></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><b>MRA</b></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><b>Orthopedic</b></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><b>Chest &amp; Body</b></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"/> 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 Other _____

**■ 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)  
 78813 NaF-18 bone metastasis (whole body)

With additional MRI Body region: \_\_\_\_\_  
 MRI Auth#: \_\_\_\_\_

**■ CT**

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

<p><b>CT Angiography</b></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><b>Spine</b></p> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic Specify levels _____ <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/coccyx
<p><b>Neuro/ENT</b></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><b>Body</b></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 Other _____
<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Joint Specify _____ <input type="checkbox"/> Extremity Specify _____ <input type="checkbox"/> Scanogram	

**■ 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 Other _____
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**■ 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)  
 78816 NaF-18 bone metastasis (whole body)

Other:

**■ Digital Mammography with CAD**

With 3D Breast Tomosynthesis

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

**Screening** (no palpable finding or symptoms)  
 Bilateral  Right  Left

**Diagnostic** - Must select reason(s)  
 Bilateral  Right  Left  
 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

**■ 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) Other _____	<p><b>Vascular</b></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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**■ Echocardiogram**

**■ Interventional Biopsy**

Breast by stereotactic  Lung  
 Breast by ultrasound  Liver  
 Thyroid  Other:

**■ Fluoroscopy**

Esophagram  Lap band  
 UGI (includes esophagram)  Hysterosalpingogram  
 UGI & small bowel series  Other:  
 Small bowel series only

**■ DXA Bone Density**

**■ Digital X-RAY** Patients can print registration forms online

<input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Facial bones <input type="checkbox"/> Nasal bones	<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"/> 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 Other:
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# ZWANGER-PESIRI RADIOLOGY

## 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
<b>74176</b>	<b>74178</b>	<b>74174</b>	<b>74170</b>	<b>74176</b>	<b>74177</b>	<b>74178</b>
•For Stone Hunt Study Only	•Urogram •Hematuria  <b>CTA ABDOMINAL AORTA TO EVALUATE STENT GRAFT 74175</b>	<b>75635-RUN OFF</b> •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 <b>Non</b> Contrast	MRCP Hemachromatosis	74181
Abdomen	MRI Abdomen <b>Pre and Post</b> IV Contrast	Kidneys Liver Pancreas Biliary Adrenals	74183
Brachial Plexus	MRI Chest <b>Non</b> Contrast	Brachial Plexus Neuropathy	71550
Chest Mediastinum	MRI Chest <b>Pre and Post</b> IV Contrast	Infection Mass Metastatic Disease Thoracic Outlet Syndrome	71552
Breast	MRI Breast <b>Pre and Post</b> IV Contrast	Breast Cancer BRCA 1/2 Positive Family History of Breast Cancer	77059
Breast	MRI Breast <b>Non</b> IV Contrast	Implant Rupture	77059
Cardiac	MRI Heart <b>Pre and Post</b> IV Contrast	Myocardial Perfusion EF Myocardial Infarction	75561
Pelvis - Female (GYN)	MRI Pelvis <b>Pre and Post</b> IV Contrast	Adenomyosis Adnexal Mass Pre-embolization Endometriomas Endometrial CA work-up Menses Problems Known Fibroids Uterine Artery Embolus Pelvic Pain Ovarian CA Rectocele Uterine Anomalies Ovarian Cysts Cystocele	72197
Pelvis - Male	MRI Pelvis <b>Pre and Post</b> IV Contrast	Prostate Rectal Staging	72197

