



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): _____ **BYUNG C KANG, DD** 192-14 Northern Blvd, Floor 2, Flushing, NY 11358
T: (718) 762-3240 F: (718) 732-3039

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 _____

Pelvis R L
 Hip R L
 Thigh R L
 Knee R L
 Lower leg R L
 Ankle R L
 Foot R L
 Toe R L

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#: _____

■ 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: _____

■ Echocardiogram

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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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

