ZWANGER-PESIRI RADIOLOGY 631-444-5544 zprad.com

NY SPORTS & JOINTS

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)

520 Franklin Avenue, Suite 211
Garden City, NY 11530
T: (212) 355-5555 F: (877) 992-0798

- ☐ **Dr Kenneth McCulloch**
- ☐ **Dr Mark Bursztyn**
- ☐ **Dr Siddhartha Sharma**
- ☐ Other _____

PATIENTS: CALL TO MAKE AN APPOINTMENT TAKE A **CELL PHONE PHOTO** OF THIS FORM AND **TEXT OR EMAIL** IT TO RX@ZPRAD.COM

RADIOLOGICAL IMAGING REFERRAL

☐ **MRI** ☐ **MR Arthrogram** Body Region _____

○ With & Without IV Contrast ○ No Contrast

○ 3T Wide-Bore ○ 1.5T Wide-Bore ○ 1.2 Open-Sided ○ Either 3T or 1.5T Wide-Bore

☐ Shoulder	☐ R ☐ L ☐ Bilateral	☐ Hip	☐ R ☐ L ☐ Bilateral
☐ Elbow	☐ R ☐ L ☐ Bilateral	☐ Knee	☐ R ☐ L ☐ Bilateral
☐ Wrist	☐ R ☐ L ☐ Bilateral	☐ Ankle	☐ R ☐ L ☐ Bilateral

☐ **CT** ☐ **CT Arthrogram** Body Region _____

○ With Contrast ○ Without Contrast ○ With & Without Contrast

○ Oral Contrast Only ○ IV Contrast Only ○ Oral & IV Contrast

☐ Shoulder	☐ R ☐ L ☐ Bilateral	☐ Hip	☐ R ☐ L ☐ Bilateral
☐ Elbow	☐ R ☐ L ☐ Bilateral	☐ Knee	☐ R ☐ L ☐ Bilateral
☐ Wrist	☐ R ☐ L ☐ Bilateral	☐ Ankle	☐ R ☐ L ☐ Bilateral

☐ **Ultrasound** Body Region _____

☐ **Nuclear Medicine** Body Region _____

☐ **Biopsy** Body Region _____

☐ **X-Ray** Body Region _____ Specify: ○ Right ○ Left ○ Bilateral

☐ Shoulder	☐ R ☐ L ☐ Bilateral ☐ AP (neutral & internal) ☐ Y view ☐ Axillary view	☐ Hand	☐ R ☐ L ☐ Bilateral
		☐ Hip	☐ R ☐ L ☐ Bilateral
		☐ Pelvis	☐ R ☐ L ☐ Bilateral
☐ Clavicle	☐ R ☐ L ☐ Bilateral	☐ Femur	☐ R ☐ L ☐ Bilateral
☐ AC Joint	☐ R ☐ L ☐ Bilateral	☐ Knee	☐ R ☐ L ☐ Bilateral
☐ Scapula	☐ R ☐ L ☐ Bilateral		☐ AP Lateral ☐ Patellar
☐ Humerus	☐ R ☐ L ☐ Bilateral		☐ AP ☐ Lateral ☐ Oblique
☐ Elbow	☐ R ☐ L ☐ Bilateral	☐ Tibula/Fibula	☐ R ☐ L ☐ Bilateral
☐ Forearm	☐ R ☐ L ☐ Bilateral	☐ Ankle	☐ R ☐ L ☐ Bilateral
☐ Wrist	☐ R ☐ L ☐ Bilateral	☐ Foot	☐ R ☐ L ☐ Bilateral

☐ **Other** _____

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