

		/ /	/ /
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)

Rudoy Medical P.C.

1577 Fultin Street, Brooklyn NY 11213
Tel# (718) 307-1577 Fax# (718) 307-1578

- Dr. Mark Ilyagu, MD
- Dr. Daniel Ganz, MD
- Dr. Celal Gurol Erbay, MD

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

■ Digital X-RAY

<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"/> 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	<input type="checkbox"/> Other:

■ MRI

Other _____

■ CT

Other _____

■ Mammography

Other _____

■ Echocardiogram

Other _____

■ Ultrasound

Other _____

■ DXA Bone Density

Other _____

■ MRI/PET

Other _____

■ Nuclear Medicine

Other _____

■ PET/CT

Other _____

■ Interventional Biopsy

Other _____

TOWN	ADDRESS	TRANSIT	FAX NUMBER
MANHATTAN HARLEM	324W 125th St, 10027	A C B D M3, M10, M100, M101, M60, BX15	(718) 696-0767
BRONX PARKCHESTER	1888 Westchester Ave, 10472	6 Q44, BX4, BX4A, BX36, BX39	(718) 696-0193
BROOKLYN COBBLE HILL	205 Smith Street, 11201	F G B57	(718) 684-7425
CROWN HTS	1128 Eastern Pkwy, 11213	2 3 4 B14, B17, B46	(718) 684-7438
QUEENS BAYSIDE	213-02 Northern Blvd, 11361	Q12, Q13, Q27, Q31, QM3, n20, n20G	(718) 684-7423
ELMHURST	88-12 Queens Blvd, 11373	R M Q59, Q60	(718) 684-7427
LAURELTON	231-35 Merrick Blvd, 11413	Q5	(718) 684-7421
OZONE PARK	102-34 Atlantic Ave, 11416	Q24	(718) 684-7429

