Suffolk Cardiovascular Consultants, P.C.

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Signature (required):

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Today's Date _____

DIAGNOSTIC IMAGING CENTER *of* EXCELLENCE™

Please ask your patients to take a cell phone photo of this referral slip in case they forget to bring it with them to our office.

Physician *Letter of Medical Necessity* Please be advised that _____ (PATIENT NAME)

_____ (DATE OF BIRTH) is presently being treated under my care. I find the test indicated below to be medically necessary.

CLINICAL INDICATIONS/SIGNS/SYMPTOMS: (MUST BE INCLUDED) _____

_____ **ICD-10:** _____

MR Angioraphy

☐ Without I.V. Contrast ☐ With & without I.V. Contrast

☐ Abdominal Aorta
- ☐ Mesenteric Arteries

☐ Thoracic Aorta
☐ Renal Arteries
☐ Aortoiliac (Pelvis)
☐ Abdominal Aorta, Aortoiliac & Peripheral Runoff Vessels
☐ Carotid Arteries
☐ Subclavian Arteries Upper Extremities
☐ Brain (Circle of Willis)

Cardiac MRI

☐ Without I.V. Contrast ☐ With & without I.V. Contrast

☐ Cardiac Function
☐ Cardiac Viability

☐ Other _____

Reason for Study

_____

_____

Computed Tomography (CT)

☐ 128/256 Slice Coronary Artery CTA
☐ Carotid CT Angiogram
☐ Chest CT
- ☐ With I.V. Contrast ☐ Without I.V. Contrast

☐ CTA abdomen Aorta and Runoff

Vascular Ultrasound

☐ 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
☐ Other _____

☐ **Other** _____