

ZWANGER-PESIRI RADIOLOGY

631-444-5544 zprad.com

CROSS BAY PHYSICAL MEDICINE AND REHABILITATION, PC

PATIENT LAST NAME	PATIENT FULL FIRST NAME	TODAY'S DATE	DATE OF BIRTH

CLINICAL INDICATIONS/SIGNS/SYMPTOMS (NOT RULE/OUT): _____

ICD-10: _____

Debra Weinstock, DPM, FACFAOM

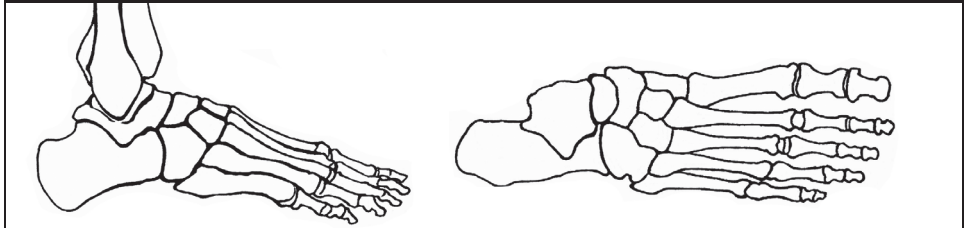
PHYSICIAN SIGNATURE (REQUIRED)

157-02 Cross Bay Blvd, Suite 202 Howard Beach, NY 11414 T: (718) 835-0100 F:(718) 843-2233

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

Please Select Part Of Foot:	MRI no contrast	MRI pre+post contrast	CT no contrast	CT post contrast
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle	<input type="checkbox"/> 73721	<input type="checkbox"/> 73723	<input type="checkbox"/> 73700	<input type="checkbox"/> 73701
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Heel	<input type="checkbox"/> 73721	<input type="checkbox"/> 73723	<input type="checkbox"/> 73700	<input type="checkbox"/> 73701
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot	<input type="checkbox"/> 73718	<input type="checkbox"/> 73720	<input type="checkbox"/> 73700	<input type="checkbox"/> 73701
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toes # _____	<input type="checkbox"/> 73718	<input type="checkbox"/> 73720	<input type="checkbox"/> 73700	<input type="checkbox"/> 73701

PLEASE MARK X AT THE LOCATION OF SUSPECTED PATHOLOGY



CLINICAL INDICATIONS

PLEASE CHECK ALL THAT APPLY

NO IV CONTRAST

BONE

Fracture
 Bone Contusion
 Osteochondritis Dissecans
 Avascular Necrosis
 Abnormal or Inconclusive X-Ray
 Abnormal or Inconclusive Bone Scan
 Other _____

SOFT TISSUE

Tendon Pathology
 Ligamentous Pathology
 Lisfranc Injury
 Plantar Disease -
 Fibromatosis or Fasciitis
 Tarsal Tunnel Syndrome
 Sinus Tarsi Syndrome
 Neuroma
 Swelling, Mass Or Lump
 Other _____

PRE + POST CONTRAST MRI

Tumor
 Cellulitis
 Infection
 Osteomyelitis
 Other _____

NUCLEAR MEDICINE

(221) Bone Scan 3 Phase 78315

X-RAY

(125) X-Ray Extremities
 R L BILATERAL

Tibia/Fibula
 Ankle
 Weight-bearing
 Heel/Calcaneus
 Foot
 Weight-bearing
 Toe Specify # _____

(129) Other _____

DIAGNOSTIC US

(109) Extremity Ultrasound 76881
 R L
 Medial ankle
 Lateral ankle
 Heel/Achilles
 Heel/Plantar fascia
 Neuroma/plantar plate
 Soft tissue mass/lump
 Other _____

INTERVENTIONAL

(177) MSK Ultrasound-Guided R L
 Aspiration Injection
 Of: _____
please specify location/joint

(178) Lab/Fluid Analysis
 Culture & Gram Stain
 Cell Count
 FNA & Cyto/Histopathology
 Other _____

(179) Other _____

VASCULAR ULTRASOUND

(108) Extremity Doppler Ultrasound
 Venous for DVT Upper Lower
 Bilateral 93970 Right 93971 Left 93971
 Venous for Insufficiency(lower)
 Arterial Upper Lower
 Bilateral 93930 Right 93931 Left 93931

(119) Other _____

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