

PATIENT LAST NAME	PATIENT FULL FIRST NAME	TODAY'S DATE	DATE OF BIRTH
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CLINICAL INDICATIONS/SIGNS/SYMPTOMS (NOT RULE/OUT): _____ ICD-10: _____

PHYSICIAN SIGNATURE (REQUIRED)	<input type="checkbox"/> Meyer H. Abittan, M.D., FACC <input type="checkbox"/> Other: _____
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2200 Northern Boulevard • Suite 211 • East Hills, NY 11548 • Tel: 516-627-1155 • Fax: 516-744-7722

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

CT (COMPUTED TOMOGRAPHY)

- 69 CTA Chest: Post IV Contrast Only 71275**
 - Aneurysm
 - Aortic Dissection
 - Pulmonary Embolism
 - Pulmonary Vein
- 70 CTA Coronary Arteries: Post IV Contrast Only 75574**
 - Stenosis
 - Occlusion
- 71 CT Calcium Scoring: No IV Contrast (self pay)**
- 93 CTA Upper Extremity R L Post IV Contrast 73206**
 - Stenosis
 - Occlusion
- 94 CTA Lower Extremity R L Post IV Contrast 73206**
 - Stenosis
 - Occlusion
- 99 Other _____**

ULTRASOUND

- 107 US Vascular**
 - Carotid Doppler 93880

