

Date: / / Patient

Referring Phys.

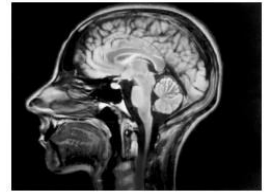
Address

Phone/Fax

CC:

Diagnostic Notes:

UNIVERSITY
DIAGNOSTIC
MEDICAL
IMAGING, P.C.



A Fully Accredited American College of Radiology Facility

1200 Waters Place Suite M108 Bronx, N.Y. 10461
Ph. 718.931.5620 Fax. 718.824.0706

Pre Authorization #

MAGENTIC RESONANCE IMAGING (MRI) OPEN HIGH FIELD HIGH FIELD Non Contrast Pre & Post Contrast

MRA (Angiography)

- | | | | | | | | | |
|---------------------------------------|--|---|---|---|-------------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="radio"/> Brain | <input type="radio"/> C Spine | <input type="radio"/> Abdomen | <input type="radio"/> Knee | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Hip | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Aorta | <input type="radio"/> Extremity-Upper |
| <input type="radio"/> Int. Aud. Canal | <input type="radio"/> T Spine | <input type="radio"/> Pelvis | <input type="radio"/> Shoulder | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> MR Arthrogram | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Brain | <input type="radio"/> Extremity-Lower |
| <input type="radio"/> Pituitary | <input type="radio"/> L Spine | <input type="radio"/> MR Cholangiogram | <input type="radio"/> Ankle | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Foot | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Chest | <input type="radio"/> Carotid/Neck |
| <input type="radio"/> Orbits | <input type="radio"/> Soft Tissue Neck | <input type="radio"/> Chest | <input type="radio"/> Wrist | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Elbow | <input type="checkbox"/> <input type="checkbox"/> | <input type="radio"/> Renal | <input type="radio"/> MRV-Brain |
| <input type="radio"/> TM Joints | <input type="radio"/> Breast | <input type="radio"/> Scrotal W/ Contrast | <input type="radio"/> Prostate w/Contrast | L R | <input type="radio"/> Other | L R | <input type="radio"/> MRV-Extremity | |

MULTISLICE HELICAL CT SCAN W/ Contrast W/O Contrast BOTH

CTA (Angiography)

PAIN MANAGEMENT

- | | | | | | |
|--|--------------------------------------|--|---|--|------------------------------------|
| <input type="radio"/> Brain | <input type="radio"/> Chest (Lung) | <input type="radio"/> Genitourinary | <input type="radio"/> Lung (screen) | <input type="radio"/> Pulmonary Artery | <input type="radio"/> Consultation |
| <input type="radio"/> Sinus | <input type="radio"/> High Res Lung | <input type="radio"/> C Spine | <input type="radio"/> Virtual Colonoscopy | <input type="radio"/> Aorta | <input type="radio"/> Epidural |
| <input type="radio"/> Soft Tissue Neck | <input type="radio"/> Abdomen | <input type="radio"/> T Spine | <input type="radio"/> Coronary Artery | <input type="radio"/> Carotid | <input type="radio"/> Nerve Block |
| <input type="radio"/> Temporal Bone | <input type="radio"/> Pelvis | <input type="radio"/> L Spine | <input type="radio"/> CT Biopsy | <input type="radio"/> Brain | Facet Block |
| <input type="radio"/> Facial / Orbit | <input type="radio"/> Abdomen/Pelvis | <input type="radio"/> Enterography-Sml Bowel | | <input type="radio"/> Other _____ | Other _____ |

Special Instructions:



New Open 1T High Field MRI
"MRI Without Walls"

Extra large opening in a sun filled room with a weight capacity of 550 lbs

NOTES

Endocrinology

MRI

W/Contrast W/O Contrast Both

- | | |
|-----------------------------|---------------------------------|
| <input type="radio"/> Brain | <input type="radio"/> Pituitary |
| <input type="radio"/> Neck | |

BUN _____ Creat _____

CT

W/Contrast W/O Contrast Both

- | | |
|--------------------------------------|-----------------------------|
| <input type="radio"/> Brain | <input type="radio"/> Chest |
| <input type="radio"/> Neck | <input type="radio"/> CTA |
| <input type="radio"/> Abdomen/Pelvis | |

BUN _____ Creat _____

ULTRASOUND

- Thyroid/Parathyroid

NUCLEAR MEDICINE

- | | |
|--|--|
| <input type="radio"/> Thyroid Scan/ Uptake | <input type="radio"/> Correlating Sono |
| <input type="radio"/> Parathyroid Scan | |
| <input type="radio"/> Hyperthyroid Therapy (I 131) | |

X-Ray

- | | |
|---|-----------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Chest |
| <input type="radio"/> (DEXA) Bone Density | |

BIOPSY

- | |
|-----------------------------------|
| <input type="radio"/> Thyroid |
| <input type="radio"/> Other _____ |