



Main Line: 718-732-0222
Appointments: Ext 2300
Office: Ext 7900

288 Saint Nicholas Ave
New York, NY 10027
Corner of 125th St • Above CVS



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

CLINICAL INDICATIONS/SIGNS/SYMPTOMS (NOT RULE/OUT)	ICD-10 CODE
--	-------------

PHYSICIAN SIGNATURE (REQUIRED)	PHYSICIAN NAME (PRINTED OR STAMPED)	PHYSICIAN ADDRESS
--------------------------------	-------------------------------------	-------------------

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

MRI

With Contrast Without Contrast

Neuro/ENT/Spine <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> IAC <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Sacrum/coccyx <input type="checkbox"/> CSF flow <input type="checkbox"/> DTI <input type="checkbox"/> Perfusion <input type="checkbox"/> TMJ <input type="checkbox"/> Soft tissue neck/parotid	MRA <input type="checkbox"/> Carotid MRA <input type="checkbox"/> Intracran/circle of Willis <input type="checkbox"/> Intracran/MR venogram <input type="checkbox"/> MR venogram Specify _____ <input type="checkbox"/> Carotid <input type="checkbox"/> Aortic arch <input type="checkbox"/> Abdominal aorta only <input type="checkbox"/> Renal arteries <input type="checkbox"/> Mesenteric arteries <input type="checkbox"/> Aorta/lower extremities
--	--

Orthopedic <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Upper arm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Finger <input type="checkbox"/> R <input type="checkbox"/> L Specify _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Thigh <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lower leg <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toe <input type="checkbox"/> R <input type="checkbox"/> L	Chest & Body <input type="checkbox"/> Chest <input type="checkbox"/> Function viability <input type="checkbox"/> Mediastinum <input type="checkbox"/> Brachial plexus <input type="checkbox"/> Scapula <input type="checkbox"/> Sternum <input type="checkbox"/> Thoracic outlet <input type="checkbox"/> Abdomen Specify _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Dynamic pelvis/MR defogram <input type="checkbox"/> Prostate <input type="checkbox"/> Enterography <input type="checkbox"/> MRCP <input type="checkbox"/> Rectal MRI
--	---

Other:

CT

With contrast Without contrast
 With and without contrast

Oral contrast only IV contrast only
 Oral and IV contrast

CT Angiography <input type="checkbox"/> Coronary artery CTA with calcium scoring (needs contrast) <input type="checkbox"/> Chest CTA/PE <input type="checkbox"/> Calcium scoring only <input type="checkbox"/> CT angiogram (needs contrast) <input type="checkbox"/> Intracranial <input type="checkbox"/> Carotid <input type="checkbox"/> Aortic arch/thoracic aorta <input type="checkbox"/> Renal <input type="checkbox"/> Lower extremity run off	MRA <input type="checkbox"/> Carotid MRA <input type="checkbox"/> Intracran/circle of Willis <input type="checkbox"/> Intracran/MR venogram <input type="checkbox"/> MR venogram Specify _____ <input type="checkbox"/> NOVA <input type="checkbox"/> Carotid <input type="checkbox"/> Aortic arch <input type="checkbox"/> Abdominal aorta only <input type="checkbox"/> Renal arteries <input type="checkbox"/> Mesenteric arteries <input type="checkbox"/> Aorta/lower extremities
---	---

Body <input type="checkbox"/> Stone hunt <input type="checkbox"/> Hematuria <input type="checkbox"/> Chest only <input type="checkbox"/> Soft tissues neck/chest/abdomen/pelvis <input type="checkbox"/> Soft tissues neck only <input type="checkbox"/> Chest/abdomen/pelvis <input type="checkbox"/> Abdomen/pelvis <input type="checkbox"/> Enterography <input type="checkbox"/> Abdomen only <input type="checkbox"/> Pelvis only <input type="checkbox"/> Triple phase liver	Neuro/ENT <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal bones <input type="checkbox"/> Paranasal sinuses <input type="checkbox"/> Soft tissues neck
--	--

Musculoskeletal <input type="checkbox"/> Joint Specify _____ <input type="checkbox"/> Extremity Specify _____ <input type="checkbox"/> Scanogram	
--	--

Other:

X-RAY

<input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Facial bones <input type="checkbox"/> Nasal bones <input type="checkbox"/> C spine <input type="checkbox"/> T spine <input type="checkbox"/> L spine <input type="checkbox"/> Sacrum <input type="checkbox"/> Chest <input type="checkbox"/> F/U abdomen <input type="checkbox"/> KUB abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Bone age <input type="checkbox"/> Ribs	<input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Fingers <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hips <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tibia/fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toes <input type="checkbox"/> R <input type="checkbox"/> L	
--	---	--

Other:

ULTRASOUND

<input type="checkbox"/> Breast <input type="checkbox"/> Bilateral R L <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotal/testicular <input type="checkbox"/> Transrectal prostate <input type="checkbox"/> Pelvis (GYN) <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <input type="checkbox"/> Transabdominal/Transvaginal <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> Obstetrical <input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta only <input type="checkbox"/> Retroperitoneum (Renal/Bladder)	<input type="checkbox"/> Echocardiogram Vascular <input type="checkbox"/> Carotid doppler <input type="checkbox"/> Venous doppler <input type="checkbox"/> Lower extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Arterial doppler <input type="checkbox"/> Lower extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Renal arterial doppler
---	---

Other:

DEXA Bone Densitometry

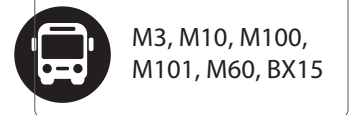
Other:



Main Line: 718-732-0222
Appointments: Ext 2300
Fax: (718) 696-0767
Office: Ext 7900

288 Saint Nicholas Ave
New York, NY 10027
Corner of 125th St • Above CVS

METRO INFORMATION



Email Scripts to:
RX@zprad.com



ZWANGER-PESIRI
RADIOLOGY

718-732-0222
zprad.com