

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

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

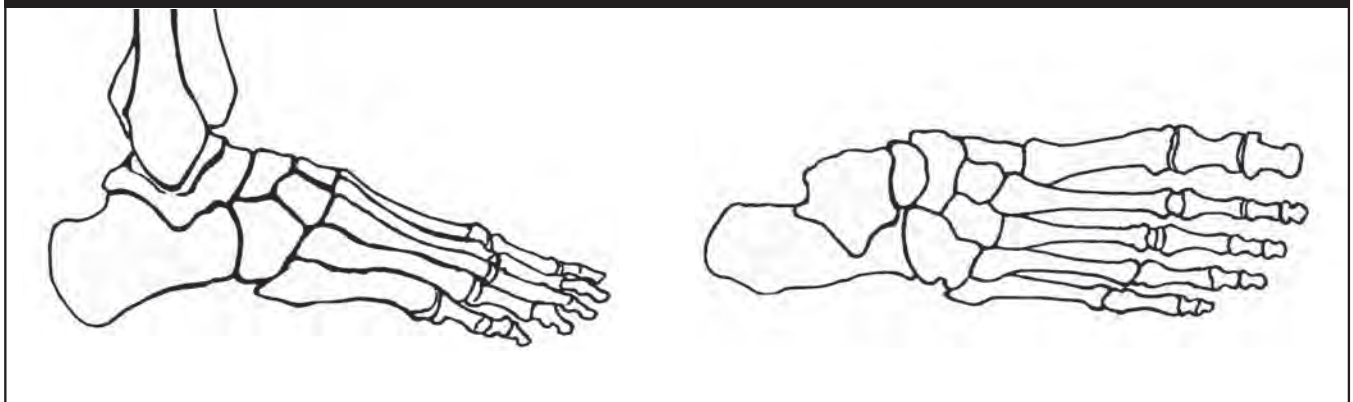
ICD-10:

 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

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/Contusion/AVN
- Osteochondritis Dissecans
- Bone Lesion
- Avascular Necrosis
- Abnormal or Inconclusive X-Ray
- Abnormal or Inconclusive Bone Scan
- Other _____

SOFT TISSUE

- Tendon Path _____
- Ligament Path _____
- Lisfranc Injury
- Plantar Fasciitis/Tear/Fibroma
- Tarsal Tunnel Syndrome
- Sinus Tarsi Syndrome
- Neuroma/Bursitis
- Swelling/Mass/Lump
- Other _____

PRE + POST CONTRAST MRI

- Soft Tissue Mass/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 _____

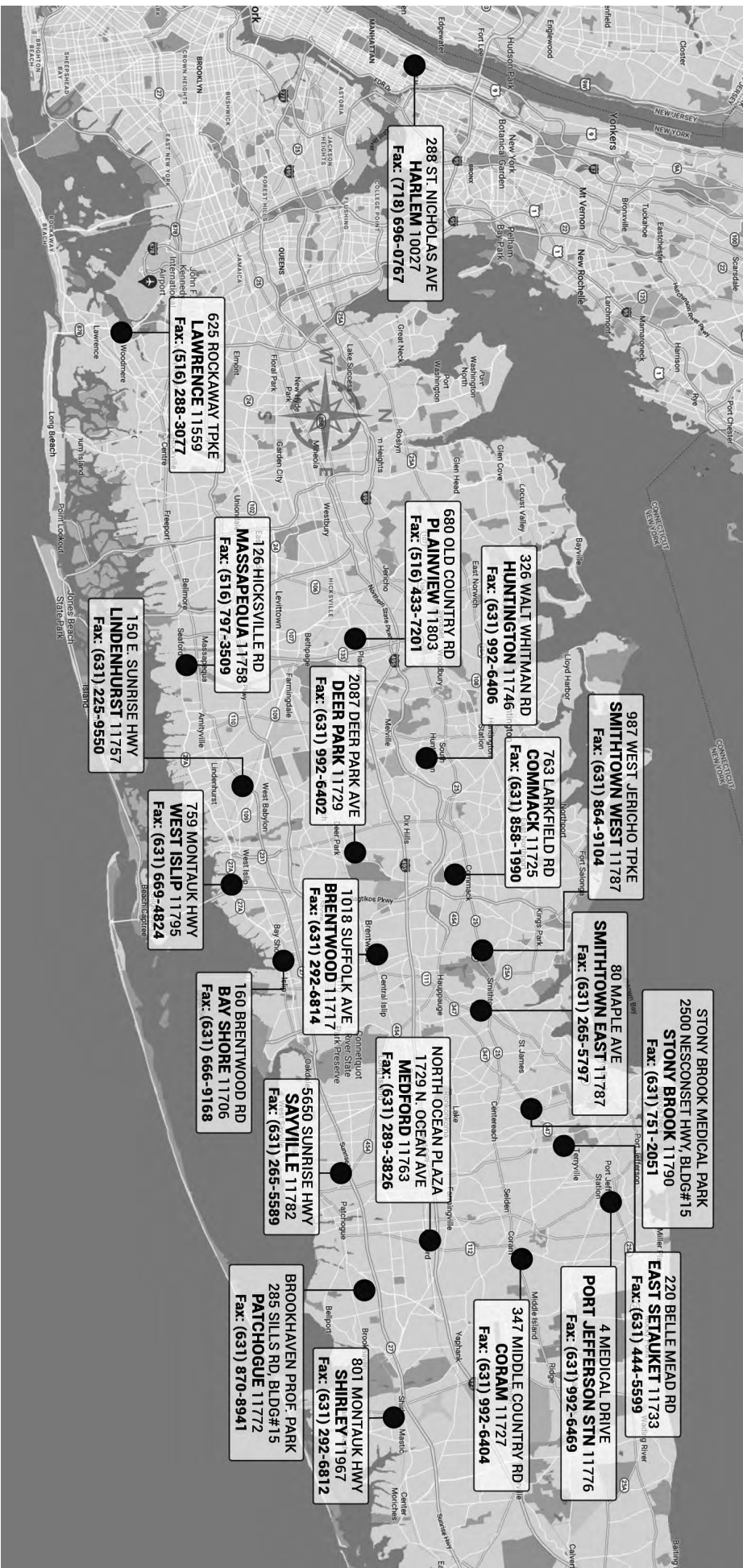
179 Other _____

VASCULAR ULTRASOUND

108 Extremity Doppler Ultrasound

- Venous for DVT Upper Lower
 - Bilateral 93970 Right 93971 Left 93971
- Arterial Upper Lower
 - Bilateral 93930 Right 93931 Left 93931

119 Other _____



**ZWANGER-PESIRI
RADIOLOGY**

**T: (631) 444-5544
F: (631) 930-9446 zprad.com**