



PATIENT NAME:.....TEL:.....

REF. PHYSICIAN:.....TEL:.....

CLINICAL HISTORY:.....

.....Date:.....

## GASTROENTEROLOGY REFERRAL FORM

MRI	
1.5 T HIGH FIELD <input type="checkbox"/>	
*IV CONTRAST: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> CHEST	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> PELVIS	
<input type="checkbox"/> MRCP	
<input type="checkbox"/> MRI ATTN: LIVER	
<input type="checkbox"/> MRI ATTN: PANCERAS	
MR ANGIOGRAM <input type="checkbox"/> ARTERIAL <input type="checkbox"/> VENOUS	
<input type="checkbox"/> OTHER .....	

CT SCAN 64-DETECTOR	
WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY	
<input type="checkbox"/> NECK	
<input type="checkbox"/> CHEST	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> PELVIS	
<input type="checkbox"/> CT SMALL BOWEL	
<input type="checkbox"/> CT PREPPED COLON (AIR)	
<input type="checkbox"/> CT BARIUM ENEMA	
<input type="checkbox"/> CT GASTROGRAFFIN ENEMA	
CT ANGIOGRAM <input type="checkbox"/> ARTERIAL <input type="checkbox"/> VENOUS	
<input type="checkbox"/> VIRTUAL COLONOSCOPY (SCREENING)	
<input type="checkbox"/> CT ATTN: PANCERAS	
<input type="checkbox"/> CT ATTN: LIVER	
<input type="checkbox"/> OTHER.....	

Ref. M.D.
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N.M.SCINTIGRAPHY	
HIDA CCK <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PYE HELICOBACTER BREATH TEST
<input type="checkbox"/> LABELLED RED CELL (HEMANGIOMA)	<input type="checkbox"/> LIVER (SULPHUR COLLOID SCAN)
<input type="checkbox"/> OCTREOTIDE	<input type="checkbox"/> GASTRIC EMPTYING SCAN
<input type="checkbox"/> MECKEL'S SCAN	<input type="checkbox"/> GALLIUM SCAN
<input type="checkbox"/> BONE SCAN	<input type="checkbox"/> BLEEDING STUDY
<input type="checkbox"/> OTHER .....	<input type="checkbox"/> SPECT IMAGING

FLUOROSCOPY	
<input type="checkbox"/> ESOPHAGRAM	<input type="checkbox"/> GI/SMALL BOWEL
<input type="checkbox"/> SMALL BOWEL SERIES	<input type="checkbox"/> POUCHOGRAM
<input type="checkbox"/> FISTULOGRAM	<input type="checkbox"/> GI SERIES
<input type="checkbox"/> VIDEO - ESOPHAGRAM	<input type="checkbox"/> BARIUM ENEMA
<input type="checkbox"/> OTHER .....	<input type="checkbox"/> GASTROGRAFFIN ENEMA

GENERAL RADIOLOGY
<input type="checkbox"/> DEXA
<input type="checkbox"/> CHEST
<input type="checkbox"/> OBSTRUCTIVE SERIES
<input type="checkbox"/> KUB
<input type="checkbox"/> MARKER STUDY
<input type="checkbox"/> OTHER.....

ULTRASOUND
<input type="checkbox"/> ABDOMEN
<input type="checkbox"/> WITH DOPPLER
<input type="checkbox"/> PELVIS
<input type="checkbox"/> WITH DOPPLER
<input type="checkbox"/> RIGHT LOWER QUADRANT
<input type="checkbox"/> RENAL
<input type="checkbox"/> SCROTAL
<input type="checkbox"/> OTHER.....

**\*IF PATIENT HAS AN ALLERGIC OR ASTHMATIC HISTORY OR IS DISABLED, PLEASE CALL (212) 535-9770 FOR INFORMATION.**

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