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

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

CLINICAL HISTORY:.....

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

NEUROLOGY/ HEAD & NECK REFERRAL FORM

MRI

1.5 T HIGH FIELD ☐

*IV CONTRAST: ☐YES ☐NO

- ☐ BRAIN
- ☐ PITUITARY
- ☐ ORBIT
- ☐ IAC
- ☐ TMJ
- ☐ NECK ATTN:.....
- ☐ OTHER .....

MR ANGIOGRAM

- ☐ BRAIN ☐ MRA ☐ MRV
- ☐ ARCH STUDY
- ☐ NECK
- ☐ OTHER .....

CT SCAN 64-DETECTOR

WE USE NON-IONIC CONTRAST MEDIA

*IV CONTRAST: ☐YES ☐NO

- ☐ BRAIN
- ☐ TEMPORAL BONE
- ☐ C-SPINE
- ☐ T-SPINE
- ☐ L-SPINE
- ☐ SINUS BRAINLAB
- ☐ LOW DOSE SINUS SURVEY
- ☐ ORBIT
- ☐ FACIAL BONES
- ☐ DENTASCAN
  - ☐ UPPER ☐ LOWER
- ☐ IAC
- ☐ NECK ATTN:.....
- ☐ CHEST
- ☐ BRACHIAL PLEXUS
- ☐ SACRAL PLEXUS
- ☐ 3D RECONSTRUCTION
- ☐ CT ANGIOGRAM
  - ☐ BRAIN ☐ NECK ☐ ARCH
- ☐ OTHER.....

Ref. M.D.

FILM PREFERENCE

- ☐ NO FILM
- ☐ CD
- ☐ FILM
- ☐ PAPER ☐ KEY IMAGES

N.M. SCINTIGRAPHY

- ☐ HIDA
- ☐ LABELLED RED CELL (HEMANGIOMA)
- ☐ BONE SCAN
- ☐ THYROID SCAN
- ☐ OTHER .....
- ☐ PARATHYROID SCAN
- ☐ GALLIUM SCAN
- ☐ OCTREOTIDE
- ☐ SPECT

ULTRASOUND

- ☐ CAROTID DOPPLER
- ☐ FOREIGN BODY/MASS
- ☐ DOPPLER ☐ UPPER EXTREMITY ☐ L ☐ R
  ☐ LOWER EXTREMITY ☐ L ☐ R

SPECIFY AREA OF INTEREST.....

- ☐ OTHER .....

PET/CT

- ☐ BRAIN PET/CT
- ☐ HEAD/NECK PET/CT
- ☐ WHOLE BODY PET/CT

GENERAL RADIOLOGY

- ☐ C-SPINE ☐ OBLIQUES ☐ FLEX/EXT ☐ STANDING
- ☐ T-SPINE ☐ OBLIQUES ☐ FLEX/EXT ☐ STANDING
- ☐ L-SPINE ☐ OBLIQUES ☐ FLEX/EXT ☐ STANDING
- ☐ SKULL
- ☐ SINUS
- ☐ NASAL/FACIAL
- ☐ SOFT TISSUE NECK
- ☐ CHEST
- ☐ SCOLIOSIS SERIES
- ☐ OTHER.....

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

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