DRS. Maklansky. Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky

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

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

CLINICAL HISTORY:..

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

ONCOLOGY REFERRAL FORM

MRI

1.5 T HIGH FIELD ☐

*IV CONTRAST: ☐YES ☐NO

- ☐ BRAIN
- ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ MRCP
- ☐ PELVIS
- ☐ MRI attn: LIVER
- ☐ MRI attn: PANCREAS
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ EXTREMITY:..
- ☐ BREAST
- ☐ MRI BONE MARROW
- ☐ PROSTATE
- ☐ MR ANGIOGRAM:...
- ☐ OTHER...

CT SCAN 64-DETECTOR

WE USE NON-IONIC CONTRAST MEDIA

*IV CONTRAST: ☐YES ☐NO

- ☐ BRAIN
- ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ CT PREPPED COLON (AIR) ☐
- ☐ VIRTUAL COLONOSCOPY (SCREENING)
- ☐ CT GASTROGRAFFIN ENEMA
- ☐ CT attn: PANCREAS
- ☐ CT attn: LIVER
- ☐ ADRENAL
- ☐ EXTREMITY:...................................... ☐
- ☐ CT SCANOGRAM BONE SURVEY
- ☐ CT ANGIOGRAM.................................
- ☐ OTHER..

Ref. M.D.

☐

FILM PREFERENCE

☐NO FILM ☐CD ☐FILM ☐PAPER
☐KEY IMAGES

PET/CT

INSULIN-DEPENDENT DIABETES REQUIRES GLUCOSE MONITORING FOR 3 DAYS

☐WHOLE BODY PET/CT

DATE OF THE LAST DIAGNOSTIC CT......................

☐DIAGNOSTIC CT ....

ULTRASOUND

- ☐THYROID
- ☐ABDOMEN ☐WITH DOPPLER
- ☐PELVIS ☐WITH DOPPLER
- ☐DOPPLER ☐UPPER EXTREMITY
  - ☐R ☐L ☐B/L
  - ☐LOWER EXTREMITY
  - ☐R ☐L ☐B/L
- ☐RIGHT LOWER QUADRANT
- ☐RENAL
- ☐SCROTAL
- ☐OTHER..

N.M. SCINTIGRAPHY

- ☐ SKULL
- ☐ NECK
- ☐ CHEST
- ☐ OBSTRUCTIVE SERIES
- ☐ KUB
- ☐ PELVIS
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ EXTREMITY:..
- ☐ OTHER...

SONOGRAM

- ☐ BONE SCAN
- ☐ MUGA GATED BLOOD POOL
- ☐ LABELLED RED CELL (HEMANGIOMA)
- ☐ OCTREOTIDE
- ☐ THYROID (123)
- ☐ OTHER ....
- ☐ SPECT IMAGING
- ☐ GALLIUM SCAN
- ☐ LIVER (SULPHUR COLLOID SCAN)
- ☐ PARATHYROID
- ☐ HIDA
- ☐ SENTINEL NODE

FLUOROSCOPY

- ☐ ESOPHAGRAM
- ☐ SMALL BOWEL SERIES
- ☐ FISTULOGRAM
- ☐ VIDEO - ESOPHAGRAM
- ☐ OTHER ....
- ☐ GI/SMALL BOWEL
- ☐ POUCHOGRAM
- ☐ GI SERIES
- ☐ BARIUM ENEMA
- ☐ GASTROGRAFFIN ENEMA
- ☐ CATHETER PATENCY STUDY

BREAST IMAGING

BRING PRIOR FILMS IF AVAILABLE

- ☐SCREENING
- ☐DIAGNOSTIC
  - [ ] BI-LATERAL
  - [ ] UNI-LATERAL...............................
- ☐MR BREAST
- ☐BREAST ULTRASOUND

DEXA

- ☐DEXA (BONE DENSIOMETRY)

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

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CT64 * MRI * CT AND MR ANGIOGRAPHY * PET/CT * CT CORONARY * CT LUNG SCREENING * ULTRASOUND/VASCULAR DOPPLER * DEXA * DIGITAL MAMMOGRAPHY * BREAST IMAGING * FLUOROSCOPY * SCINTIGRAPHY * X-RAY