



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

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

CLINICAL HISTORY:.....

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

ORTHOPEDIC REFERRAL FORM

MRI		
1.5 T HIGH FIELD <input type="checkbox"/>		
*IV CONTRAST: <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> C-SPINE		
<input type="checkbox"/> T-SPINE		
<input type="checkbox"/> L-SPINE		
<input type="checkbox"/> PELVIS/HIPS		
<input type="checkbox"/> SACRUM/COCCYX		
<input type="checkbox"/> BONE SURVEY		
EXTREMITIES		
LEFT	RIGHT	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> KNEE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SHOULDER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ANKLE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ELBOW
<input type="checkbox"/> MR ARTHROGRAM		
<input type="checkbox"/> DIRECT <input type="checkbox"/> INDIRECT		
<input type="checkbox"/> OTHER		

CT SCAN 64-DETECTOR	
WE USE NON-IONIC CONTRAST MEDIA	
*IV CONTRAST: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> C-SPINE	
<input type="checkbox"/> T-SPINE	
<input type="checkbox"/> L-SPINE	
<input type="checkbox"/> PELVIS/HIPS	
<input type="checkbox"/> SACRUM/COCCYX	
<input type="checkbox"/> 3D REFORMATTING	
<input type="checkbox"/> EXTREMITY <input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> CT ANGIOGRAM	
<input type="checkbox"/> CT ARTHROGRAM.....	
<input type="checkbox"/> CT SCANOGRAM.....	
<input type="checkbox"/> OTHER.....	

Ref. M.D.		
FILM PREFERENCE		
<input type="checkbox"/> NO FILM		
<input type="checkbox"/> CD		
<input type="checkbox"/> FILM		
<input type="checkbox"/> PAPER <input type="checkbox"/> KEY IMAGES		
GENERAL RADIOLOGY		
<input type="checkbox"/> C-SPINE <input type="checkbox"/> OBLIQUES <input type="checkbox"/> FLEX/EXT <input type="checkbox"/> STANDING		
<input type="checkbox"/> T-SPINE <input type="checkbox"/> OBLIQUES <input type="checkbox"/> FLEX/EXT <input type="checkbox"/> STANDING		
<input type="checkbox"/> L-SPINE <input type="checkbox"/> OBLIQUES <input type="checkbox"/> FLEX/EXT <input type="checkbox"/> STANDING		
<input type="checkbox"/> CHEST		
<input type="checkbox"/> ABDOMEN		
<input type="checkbox"/> PELVIS		
<input type="checkbox"/> RIBS		
<input type="checkbox"/> SACRUM/COCCYX		
<input type="checkbox"/> SCOLIOSIS SERIES		
<input type="checkbox"/> BONE AGE		
<input type="checkbox"/> LIMB LENGHT SCANOGRAM		
<input type="checkbox"/> OTHER.....		
EXTREMITIES		
LEFT	RIGHT	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SHOULDER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HUMERUS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RADIUS/ULNA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ELBOW
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> WRIST
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HAND
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HIP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> FEMUR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> KNEE
<input type="checkbox"/> STANDING VIEWS <input type="checkbox"/> PATELLAR VIEWS		
<input type="checkbox"/> PATELLA		
<input type="checkbox"/> TIBIA/FIBULA		
<input type="checkbox"/> ANKLE		
<input type="checkbox"/> FOOT		
<input type="checkbox"/> STRESS VIEWS (SPECIFY):.....		
<input type="checkbox"/> OTHER		

N.M. SCINTIGRAPHY	
<input type="checkbox"/> BONE SCAN	<input type="checkbox"/> GALLIUM SCAN
<input type="checkbox"/> 3 PHASE BONE SCAN	<input type="checkbox"/> SPECT
<input type="checkbox"/> OTHER	
SONOGRAM	
<input type="checkbox"/> POPLITEAL CYST.....	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> FOREIGN BODY
<input type="checkbox"/> DOPPLER	<input type="checkbox"/> UPPER EXTREMITY <input type="checkbox"/> L <input type="checkbox"/> R
	<input type="checkbox"/> LOWER EXTREMITY <input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> OTHER	
DEXA	
<input type="checkbox"/> DEXA	<input type="checkbox"/> DEXA W/IVA

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

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