



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

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

CLINICAL HISTORY:.....

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

### UROLOGY REFERRAL FORM

MRI	
1.5 T HIGH FIELD <input type="checkbox"/>	
*IV CONTRAST: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> BRAIN	
<input type="checkbox"/> CERVICAL SPINE	
<input type="checkbox"/> THORACIC SPINE	
<input type="checkbox"/> LOMBAR SPINE	
<input type="checkbox"/> SPINE SURVEY	
<input type="checkbox"/> CHEST	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> SCROTUM	
MR UROGRAM	
MR ANGIOGRAPHY	
<input type="checkbox"/> PELVIS	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> RENAL ARTERY	
<input type="checkbox"/> OTHER.....	

CT SCAN 64-DETECTOR	
WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY	
<input type="checkbox"/> CHEST	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> PELVIS	
<input type="checkbox"/> ABDPELFOR	
<input type="checkbox"/> MICRO HEMATURIA	
<input type="checkbox"/> CT STONE STUDY	
<input type="checkbox"/> CT UROGRAPHY	
<input type="checkbox"/> CT BARIUM ENFMA	
<input type="checkbox"/> CT PREPPED COLON	
<input type="checkbox"/> CERVICAL SPINE	
<input type="checkbox"/> TORACIC SPINE	
<input type="checkbox"/> LUMBAR SPINE	
<input type="checkbox"/> OTHER .....	

Ref. M.D.	
CT ANGIOGRAPHY	
WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY	
<input type="checkbox"/> RENAL ARTERY	
<input type="checkbox"/> ABD.....PEL.....	
<input type="checkbox"/> OTHER.....	

SCINTIGRAPHY	
<input type="checkbox"/> WHOLE BODY BONE SCAN	
<input type="checkbox"/> LIMITED AREA BONE SCAN	
<input type="checkbox"/> 3-PHASE BONE SCAN	
<input type="checkbox"/> RENAL SCAN	
<input type="checkbox"/> LASIX RENAL SCAN	
<input type="checkbox"/> CAPTOPRIL RENAL SCAN	
<input type="checkbox"/> OTHER .....	

ULTRASOUND	
<input type="checkbox"/> ABDOMEN	
<input type="checkbox"/> PELVIS (TRANSABDOMINAL)	
<input type="checkbox"/> TRANSVAGINAL	
<input type="checkbox"/> TRANSVAGINAL (before 12 weeks gestation)	
<input type="checkbox"/> RENAL	
<input type="checkbox"/> SCROTUM	
<input type="checkbox"/> BLADDER	
<input type="checkbox"/> AORTA SCREENING	
<input type="checkbox"/> OTHER.....	

FLUOROSCOPY	
<input type="checkbox"/> IVP	
<input type="checkbox"/> OTHER .....	

PET/CT	
<input type="checkbox"/> WHOLE BODY PET/CT	
<input type="checkbox"/> BRAIN PET/CT	
<input type="checkbox"/> DIAGNOSTIC CT.....	

X-RAY	
<input type="checkbox"/> CHEST.....AP.....PA/LAT	
<input type="checkbox"/> ABD.....FLAT.....	
<input type="checkbox"/> ERECT .....OBS.....	
<input type="checkbox"/> OTHER.....	

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

Daniel Maklansky, M.D.  
Alain D. Hyman, M.D.

Jerold Kurzban, M.D.  
Barry D. Berson, M.D.

Burton A. Ccohen, M.D.  
Joseph J. Maklansky, M.D.

Jerald Zimmer, M.D.  
Jolinda Mester, M.D.