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 James McCleavey, M.D., DABR
 Howard Gelber, M.D., DABR
 Glenn Schwartz, M.D., DABR

Daniel Beyda, M.D., DABR
 Victoria Beyda, M.D., DABR
 Matthew Diamant, M.D., DABR
 Myrna Nussbaum, M.D., DABR

Patient's Name _____ Date _____
 Referring Physician _____ Pre-Cert # _____
 History/Diagnosis _____

<p>MRI</p> <p><input type="checkbox"/> Cervical Spine <input type="checkbox"/> w/contrast</p> <p><input type="checkbox"/> Thoracic Spine <input type="checkbox"/></p> <p><input type="checkbox"/> Lumbar Spine <input type="checkbox"/></p> <p><input type="checkbox"/> Brain <input type="checkbox"/></p> <p><input type="checkbox"/> Pituitary <input type="checkbox"/></p> <p><input type="checkbox"/> IACs <input type="checkbox"/></p> <p><input type="checkbox"/> Orbits <input type="checkbox"/></p> <p><input type="checkbox"/> Sinuses <input type="checkbox"/></p> <p><input type="checkbox"/> TMJ <input type="checkbox"/></p> <p><input type="checkbox"/> Brachial Plexus <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/></p> <p><input type="checkbox"/> Pelvis <input type="checkbox"/></p> <p><input type="checkbox"/> Other _____</p> <p>Extremities</p> <table border="0"> <tr><td></td><td>Rt</td><td>Lt</td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Elbow</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Wrist</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Knee</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Ankle</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Other _____</td><td></td><td></td></tr> </table> <p>MR Angiography</p> <p><input type="checkbox"/> Intracranial</p> <p><input type="checkbox"/> Carotid</p> <p><input type="checkbox"/> Thoracic</p> <p><input type="checkbox"/> Abdominal</p> <p><input type="checkbox"/> Renal</p> <p>MR Venogram</p> <p><input type="checkbox"/> Brain</p> <p>Magnetic Resonance Mammography</p> <p><input type="checkbox"/> Uni_____ <input type="checkbox"/> Bilat.</p> <p>AVAILABLE AT HEWLETT LOCATION</p>		Rt	Lt	<input type="checkbox"/> Shoulder	<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"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____			<p>CT SCAN</p> <p><input type="checkbox"/> Brain <input type="checkbox"/> w/contrast</p> <p><input type="checkbox"/> Pituitary <input type="checkbox"/></p> <p><input type="checkbox"/> Orbits <input type="checkbox"/></p> <p><input type="checkbox"/> Temporal Bones <input type="checkbox"/></p> <p><input type="checkbox"/> Sinuses <input type="checkbox"/></p> <p><input type="checkbox"/> Neck <input type="checkbox"/></p> <p><input type="checkbox"/> Chest <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/></p> <p><input type="checkbox"/> Pelvis <input type="checkbox"/></p> <p><input type="checkbox"/> Cervical Spine <input type="checkbox"/></p> <p><input type="checkbox"/> Thoracic Spine <input type="checkbox"/></p> <p><input type="checkbox"/> Lumbar Spine <input type="checkbox"/></p> <p><input type="checkbox"/> Other _____</p> <p>CT Angiography</p> <p><input type="checkbox"/> Carotid Arteries</p> <p><input type="checkbox"/> Intracranial Vessels (Head)</p> <p><input type="checkbox"/> Thoracic Aorta</p> <p><input type="checkbox"/> Pulmonary Artery</p> <p><input type="checkbox"/> Renal Arteries</p> <p><input type="checkbox"/> Abdominal Aorta</p> <p>SONOGRAPHY</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Pelvis/Transabdominal</p> <p><input type="checkbox"/> Pelvis/Transvaginal</p> <p><input type="checkbox"/> Pelvis/Transrectal</p> <p><input type="checkbox"/> OB Sono/Biophysical Profile</p> <p><input type="checkbox"/> Sono Hysterogram</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Breast <input type="checkbox"/> Bil <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p><input type="checkbox"/> Testicular / Scrotum</p> <p><input type="checkbox"/> Renal/Kidney</p> <p><input type="checkbox"/> Hepatobiliary</p> <p><input type="checkbox"/> Aorta</p> <p><input type="checkbox"/> Other _____</p>	<p>NUCLEAR MEDICINE</p> <p><input type="checkbox"/> Bone Scan</p> <p><input type="checkbox"/> Hepatobiliary</p> <p><input type="checkbox"/> Liver/Spleen Scan</p> <p><input type="checkbox"/> Renal Scan <input type="checkbox"/> Lasix®</p> <p><input type="checkbox"/> Function <input type="checkbox"/> Morphology</p> <p><input type="checkbox"/> Thyroid Scan with Uptake</p> <p><input type="checkbox"/> Other _____</p> <p>CARDIOLOGY</p> <p><input type="checkbox"/> Muga</p> <p><input type="checkbox"/> Resting <input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Stress Cardiolute (SPECT)</p> <p><input type="checkbox"/> Exercise <input type="checkbox"/> Persantine</p> <p><input type="checkbox"/> Thallium</p> <p><input type="checkbox"/> Exercise <input type="checkbox"/> Pharmacological</p> <p>AVAILABLE IN THE ASTORIA & FOREST HILLS LOCATIONS</p> <p><input type="checkbox"/> ECHOCARDIOGRAM W/COLOR DOPPLER</p> <p>AVAILABLE IN ELMONT AND FOREST HILLS LOCATION</p> <p>COLOR DOPPLER</p> <p><input type="checkbox"/> Carotid <input type="checkbox"/> Hepatic</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> Renal</p> <p>Lower Extremity</p> <p><input type="checkbox"/> Arterial <input type="checkbox"/> Bil <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p><input type="checkbox"/> Venous <input type="checkbox"/> Bil <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>MAMMOGRAPHY</p> <p><input type="checkbox"/> Screening <input type="checkbox"/> Uni_____ <input type="checkbox"/> Bilat.</p> <p><input type="checkbox"/> Diagnostic <input type="checkbox"/> Uni_____ <input type="checkbox"/> Bilat.</p> <p><input type="checkbox"/> Stereotactic Biopsy <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>UNAVAILABLE IN THE ASTORIA LOCATION</p> <p>BONE DENSITY</p> <p><input type="checkbox"/> _____</p> <p>UNAVAILABLE IN THE ASTORIA LOCATION</p>	<p>X-RAY</p> <p>Skeletal</p> <p><input type="checkbox"/> Skull</p> <p><input 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type="checkbox"/> Chest PA & Lateral</p> <p><input type="checkbox"/> Other _____</p> <p>Abdomen</p> <p><input type="checkbox"/> Flat/Upright</p> <p><input type="checkbox"/> KUB</p> <p><input type="checkbox"/> IVP</p> <p><input type="checkbox"/> Other _____</p> <p>FLUOROSCOPY</p> <p><input type="checkbox"/> Esophogram</p> <p><input type="checkbox"/> Upper GI</p> <p><input type="checkbox"/> Small Bowel Series</p> <p><input type="checkbox"/> Barium Enema</p> <p><input type="checkbox"/> Hysterosalpingogram</p> <p><input type="checkbox"/> Other _____</p> <p>UNAVAILABLE IN THE FOREST HILLS LOCATION</p>		Rt	Lt	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Humerus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Radius/ULna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input 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MRI Information: MRI is contraindicated in patients with Pacemakers, Ear Implants, and Cerebral Aneurysm Clips. PTO for more information.
MRI, CT and IVP Contrast Study Information: BUN _____ / CREAT _____
 If you have Asthma or Allergies, please premedicate.
 Diabetic Patients needing contrast, please alert our staff at the time of your appointment.