



CT SCAN

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax #:
Clinical History:		
Is the patient diabetic? Yes No	If yes, list medications:	
BUN: _____ CR: _____		
Is the patient pregnant? Yes No	Does the patient have a pacemaker? Yes No	
Physician Signature:		Date:

CT SCAN Contrast: Without IV contrast With IV contrast Oral contrast Only

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Chest | <input type="checkbox"/> Dentascan |
| <input type="checkbox"/> Paranasal Sinus | <input type="checkbox"/> Chest (High Res) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Abdomen | |
| <input type="checkbox"/> IAC / Temporal Bones | <input type="checkbox"/> Pelvis | |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Upper Extremity | |
| <input type="checkbox"/> Soft Tissue Neck | Location: _____ | |
| <input type="checkbox"/> Cervical Spine | Specify <input type="checkbox"/> R <input type="checkbox"/> L | |
| <input type="checkbox"/> Thoracic | <input type="checkbox"/> Lower Extremity | |
| <input type="checkbox"/> Lumbar | Location: _____ | |
| | Specify <input type="checkbox"/> R <input type="checkbox"/> L | |

Hours of Operation: Monday – Friday 9:30am – 6pm

Please call 212.410.5100 to schedule an appointment.

Appointment Date / Time: _____ Auth #: _____

Please have your insurance card available. **Please Note:** Co-payments are collected at time of visit.