



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		
Physician Signature:		Date:

CT SCAN Contrast: <input type="radio"/> Without IV <input type="radio"/> WITH IV <input type="radio"/> Oral contrast Only <input type="radio"/> OTHER		
<input type="checkbox"/> Brain <input type="checkbox"/> Paranasal Sinus <input type="checkbox"/> Orbits <input type="checkbox"/> IAC/Temporal Bones <input type="checkbox"/> Facial Bones <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar <input type="checkbox"/> Chest <input type="checkbox"/> Chest (High Res) <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Upper Extremity Location: _____ Specify <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lower Extremity Location: _____ Specify <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> CTA Abdomen <input type="checkbox"/> CTA Chest <input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Lower Extremity <input type="checkbox"/> CTA Upper Extremity <input type="checkbox"/> Other _____

Hours of Operation: Monday –Friday 8am-3:30pm; Wednesdays 8am-7pm; Every other Saturday 8am –12pm, Sunday 9am-4pm Please call 212.977.4100 to schedule an appointment.	
Appointment Date/Time: _____	Pre-Auth#: _____
Please have your insurance card available. Please Note: Co-payments are collected at time of visit.	