



**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.