



**CT**

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:**     Without IV     WITH IV     Oral contrast Only

- Brain
- Orbits
- IAC / Temporal Bones
- Facial Bones
- Soft Tissue Neck
- Cervical Spine
- Thoracic
- Lumbar

- Chest
- Chest (High Res)
- Abdomen
- Pelvis
- Upper Extremity/Joint: \_\_\_\_\_
- Lower Extremity/Joint: \_\_\_\_\_

**CTA**

- Abdomen
- Pelvis
- Chest
- Head
- Neck
- Other \_\_\_\_\_

**Available appointment times for CT Exams: Monday – Friday 8am – 4pm**

**Please call 718.758.1500 to schedule an appointment.**

Appointment Date / Time: \_\_\_\_\_ Pre-Certification #: \_\_\_\_\_

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