



NUCLEAR MEDICINE

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:
Is the patient pregnant?	Yes No	Is the patient claustrophobic? Yes No
Physician Signature:		Date:

NUCLEAR MEDICINE	
<input type="checkbox"/> Bone Whole Body/Limited	<input type="checkbox"/> Kidney
<input type="checkbox"/> Bone 3 Phase	<input type="radio"/> Captopril
<input type="radio"/> _____	<input type="radio"/> Lasix
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Liver/Spleen
<input type="radio"/> _____	<input type="checkbox"/> Lung
<input type="checkbox"/> Gallbladder Contractility	<input type="radio"/> _____
<input type="checkbox"/> Hepatobiliary (HIDA)	<input type="checkbox"/> Parathyroid
<input type="radio"/> w/CCK	<input type="checkbox"/> Treatment _____
<input type="checkbox"/> Gallium Scan	_____
<input type="radio"/> Infection Abscess	_____
<input type="radio"/> Tumor Imaging	<input type="checkbox"/> Other _____
<input type="radio"/> _____	_____
<input type="checkbox"/> Thyroid Uptake & Scan	_____
<input type="radio"/> Technetium	_____

<p>Please call 718.758.1500 to schedule an appointment.</p> <p>Appointment Date / Time: _____ Pre-Certification #: _____</p> <p>Please have your insurance card available. Please Note: Co-payments are collected at time of visit.</p>
