



**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:

<b>CT SCAN</b> Contrast: <input type="radio"/> Without IV contrast <input type="radio"/> With IV contrast <input type="radio"/> Oral contrast Only		
<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 _____
<b>Hours of Operation: Monday – Friday 8am – 6pm</b>		

<p><b>Please call 212.473.2300 to schedule an appointment.</b></p> <p>Appointment Date / Time: _____ Pre-Auth #: _____</p> <p>Please have your insurance card available. <b>Please Note: Co-payments are collected at time of visit.</b></p>
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