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PATIENT NAME _____ DATE ____/____/____ TIME: ____:____

CLINICAL HISTORY:

1.5T MAGNETIC RESONANCE IMAGING		CT 16 MULTIDETECTOR / SPIRAL		PET/CT SCANNING	
WITH CONTRAST []		WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY		BRING PRIOR MRI AND CT FILM IF DONE AT OTHER FACILITY	
<input type="checkbox"/> Brain 70553 <input type="checkbox"/> Orbits 70543 <input type="checkbox"/> IAC 70553 <input type="checkbox"/> Facial 70543 <input type="checkbox"/> Neck 70543 <input type="checkbox"/> TMJ 70336 <input type="checkbox"/> Pituitary 70553 <input type="checkbox"/> Cervical Spine 72156 <input type="checkbox"/> Thoracic Spine 72157 <input type="checkbox"/> Lumbar Spine 72158 <input type="checkbox"/> Chest 71552 <input type="checkbox"/> Abdomen 74183 <input type="checkbox"/> MRCP (Biliary) R L B 74183 <input type="checkbox"/> Pelvis 72197 <input type="checkbox"/> Breast R L B 76093 <input type="checkbox"/> Shoulder R L B 73223 <input type="checkbox"/> Shoulder Arthrogram R L B 73321/73040 <input type="checkbox"/> Hip Arthrogram R L B 73525/73721 <input type="checkbox"/> Arm R L B 73220 <input type="checkbox"/> Elbow R L B 73223 <input type="checkbox"/> Wrist R L B 73223 <input type="checkbox"/> Hand R L B 73220 <input type="checkbox"/> Hip R L B 73723 <input type="checkbox"/> Leg_femur_TIBFIB R L B 73720 <input type="checkbox"/> Knee R L B 73723 <input type="checkbox"/> Ankle R L B 73723 <input type="checkbox"/> Foot R L B 73720 <input type="checkbox"/> Prostate 72197 <input type="checkbox"/> MR Myelogram 72148 <input type="checkbox"/> Other _____		WITH CONTRAST [] <input type="checkbox"/> Head 70470 <input type="checkbox"/> Orbits 70482 <input type="checkbox"/> IACS 70482 <input type="checkbox"/> Temporal Bones 70482 <input type="checkbox"/> Pituitary 70482 <input type="checkbox"/> Sinuses 70486 <input type="checkbox"/> Sinuses With VTI 70486 <input type="checkbox"/> Maxillofacial 70486 <input type="checkbox"/> Soft Tissue Neck 70492 <input type="checkbox"/> Mandible (Non Dental) 70486 <input type="checkbox"/> Abdomen 74170 <input type="checkbox"/> Pelvis 72194 <input type="checkbox"/> Chest 71270 <input type="checkbox"/> Pulmonary Angio 71275 <input type="checkbox"/> Shoulder Arthrogram 73040/73200 <input type="checkbox"/> Cervical Spine 72127 <input type="checkbox"/> Thoracic Spine 72130 <input type="checkbox"/> Lumbar Spine 72133 <input type="checkbox"/> Leg_femur_TIBFIB R L B 73702 <input type="checkbox"/> Foot R L B 73702 <input type="checkbox"/> Arm R L B 73202 <input type="checkbox"/> Humerus R L B 73202 <input type="checkbox"/> Radius/ULNA R L B 73202 <input type="checkbox"/> Other _____ <input type="checkbox"/> BUN/CR		WITH DIAGNOSTIC CT SCAN [] Eyes To Thighs 78815 <input type="checkbox"/> SPN <input type="checkbox"/> NSCLC <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Thyroid Cancer <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Esophageal Cancer <input type="checkbox"/> Head & Neck Cancer Specific Diagnosis (Excluding Thyroid And Cns Cancer) <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Cervical <input type="checkbox"/> Lymphoma Whole Body 78816 <input type="checkbox"/> Melanoma Brain 78609 <input type="checkbox"/> Brain Tumor / Perfusion <input type="checkbox"/> Alzheimers / Seizure Other _____ <input type="checkbox"/> BUN/CR	
MR ANGIOGRAPHY		SCREENING STUDIES			
<input type="checkbox"/> Head / Brain 70546 <input type="checkbox"/> Neck 70549 <input type="checkbox"/> Chest 71555 <input type="checkbox"/> Carotid 70549 <input type="checkbox"/> Pelvis 72198 <input type="checkbox"/> Abdomen 74185 <input type="checkbox"/> Lower Extremity 73725		WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY <input type="checkbox"/> CT Dental Scan Mandible <input type="checkbox"/> CT Dental Scan Maxilla <input type="checkbox"/> CT Total Body Scan <input type="checkbox"/> Coronary Angiography <input type="checkbox"/> Virtual Colonoscopy <input type="checkbox"/> Heart + Lung Screening <input type="checkbox"/> Coronary Calcium (Heart) Screening <input type="checkbox"/> Pulmonary Nodule (Lung) Screening <i>These studies are not covered by insurance</i>			
NUCLEAR MEDICINE		MAMMOGRAPHY / BREAST IMAGING			
BONE SCAN <input type="checkbox"/> - Whole Body 78306 <input type="checkbox"/> - Limited Area 78300 <input type="checkbox"/> - 3 Phase 78315 <input type="checkbox"/> Gallium 78802 <input type="checkbox"/> Liver 78215 <input type="checkbox"/> Lung Perfusion Only 78580 <input type="checkbox"/> Thyroid 1 ¹²³ 78010 <input type="checkbox"/> Parathyroid 78070 <input type="checkbox"/> Renal 78707 <input type="checkbox"/> Hida 78223		BRING PRIOR MRI AND CT FILM IF DONE AT OTHER FACILITY <input type="checkbox"/> Screening <input type="checkbox"/> Additional studies / views at radiologists' discretion if necessary, check here. 76092 <input type="checkbox"/> Diagnostic <input type="checkbox"/> 76091 <input type="checkbox"/> [] Bi-lateral [] Spot Compression <input type="checkbox"/> [] Unilateral [] Implants <input type="checkbox"/> [] Magnification Views <input type="checkbox"/> MRI Breast R L B 76093 <input type="checkbox"/> Breast Sono R L B 76645			
BONE DENSITOMETRY		BIOPSY CT GUIDED / FNA			
<input type="checkbox"/> DEXA 76075		BRING FILMS IF AVAILABLE <input type="checkbox"/> Breast FNA R L B 10022 <input type="checkbox"/> Breast Core R L B 19102 <input type="checkbox"/> Breast Mri Biopsy R L B 10022 <input type="checkbox"/> Thyroid FNA 76360 <input type="checkbox"/> Other _____			
ULTRASOUND					
<input type="checkbox"/> Abdomen 76700 <input type="checkbox"/> Pelvis (Transabdominal) 76856 <input type="checkbox"/> Transvaginal 76830 <input type="checkbox"/> Transvaginal (Before 12 Weeks Gestation) 76817 <input type="checkbox"/> Obstetric (Level II) Anatomy 76805 <input type="checkbox"/> Obstetric Biophysical Profile 76818 <input type="checkbox"/> Breast 76645 <input type="checkbox"/> Sonohysterogram 58340/76831 <input type="checkbox"/> Thyroid 76536 <input type="checkbox"/> Renal 76770 <input type="checkbox"/> Scrotum 76870 <input type="checkbox"/> Transrectal 76872 <input type="checkbox"/> Extremity Non-vascular 76880 <input type="checkbox"/> Duplex Carotid 93880 <input type="checkbox"/> Venous Extremity (Upper) R L B 93970 <input type="checkbox"/> Venous Extremity (Lower) R L B 93971 <input type="checkbox"/> Arterial Extremity (Upper) R L B 93930 <input type="checkbox"/> Arterial Extremity (Lower) R L B 93925 <input type="checkbox"/> Other _____					
X-RAY/FLUOROSCOPY					
<input type="checkbox"/> Chest <input type="checkbox"/> AP <input type="checkbox"/> PA/LAT <input type="checkbox"/> Facial Bones Nasal Bones Mandible <input type="checkbox"/> Ribs <input type="checkbox"/> Abdomen <input type="checkbox"/> Flat <input type="checkbox"/> Erect <input type="checkbox"/> Thoracic <input type="checkbox"/> Standing <input type="checkbox"/> Cervical Sp <input type="checkbox"/> 2 Views <input type="checkbox"/> 4 Views <input type="checkbox"/> Standing <input type="checkbox"/> Lumbar Sp <input type="checkbox"/> 2 Views <input type="checkbox"/> 4 Views <input type="checkbox"/> Standing <input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI Series <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> GI Series Small Bowel <input type="checkbox"/> Hysterosalpinogram <input type="checkbox"/> GI Series Esophagram <input type="checkbox"/> Other _____					

Requested by Dr. _____
 Images: Yes No
 Address: _____

Fax Report: Yes No
 Fax Number: _____
 Email Report: Yes No
 Email Address: _____

PRECERT #: _____

PREPARATION FOR DIAGNOSTIC EXAMINATIONS

When making your appointment please inform the office if you are **PREGNANT**. Patients who are elderly, or have diabetes or any condition which prevents them from following a preparation, should consult their physician.

MAGNETIC RESONANCE IMAGING

You **cannot** have a MRI if you have;

1. A CARDIAC PACEMAKER
2. A BRAIN ANEURYSM CLIP MORE THAN 10 YEARS OLD.
3. A MIDDLE EAR PROSTHESIS
4. NEUROSTIMULATORS
5. HAD SURGERY IN THE PAST WEEK.

Please advise the technologist if you have any prosthetic device (ie., hip or knee replacement etc.) If patient requires tranquilizer, please arrive 1/2 hour prior to the appointment, and must be accompanied by a companion. All patients must remove all jewelry, hair pins and other metallic accessories for the procedure. Patients should not wear any eye makeup. Headphones are available during the procedure. You may bring your own CD.

CT SCAN HEAD OR BODY W/ CONTRAST

(We use non-ionic contrast exclusively)

Do not eat, drink or chew anything 3 hours prior to the exam. It is important to advise the technologist, prior to the exam, if you have a history of iodine allergy or anaphylactic reaction.

PET/CT

NEUROLOGIC:

Nothing to eat or drink other than water 4 hours to prior to exam.

CARDIAC:

No caffeinated drinks or medications 24 hours prior to exam. Eat a high carbohydrate meal for breakfast on the day of the exam. (i.e., pancakes, grain cereals, toast, bagels, etc.)

ONCOLOGY:

Nothing to eat or drink other than water for 4 hours prior to exam. Four glasses of water are encouraged and should be consumed in the four hour time period before the exam. No carbohydrates 12-24 hours prior to the exam. No exercise for 36-48 hours prior to exam. Do not chew gum for 24 hours prior to scan.

-Please report to exam location 30 minutes prior to appointment time.

-If you are a **DIABETIC**, please call your physician regarding blood sugar control and diet requirements two day prior to your scheduled exam. Blood sugar level should be less than 200mg/dl.

-If there is a possibility of **PREGNANCY** please inform our staff prior to your exam.

-Valium (diazepam) for claustrophobic or extremely anxious patients (with written approval from your doctor). Someone must accompany the patient after the exam.

-Please expect to be in our office approximately 3-4 hours.

ULTRASOUND

ABDOMINAL

Nothing to eat, drink or chew 6 hours prior to the procedure.

PELVIC

Your bladder must be full for the exam.

1. Two hours before the appointment empty bladder. Do not urinate again until the exam is completed.
2. One hour before the appointment, drink 32 oz of water (4 glasses).
3. See the receptionist if you feel you must urinate prior to the exam.

MAMMOGRAPHY

(please bring prior year's films if available)

Do not wear deodorant, powder or lotion on the breast or underarm area. If available, please bring previous mammogram films with you for comparison. If you are nursing or recently post partum, please advise the office in advance.

DEXA SCAN

Do not take any calcium pills 24 hours prior to the exam.

NUCLEAR THYROID UPTAKE AND SCAN

NOTE: IF YOU ARE PREGNANT OR ACTIVELY NURSING, YOU SHOULD NOT HAVE A NUCLEAR EXAM. PLEASE CONSULT YOUR PHYSICIAN.

1. No salt, no vitamins, no fish or food that contains salt, 48 hours prior to the exam.
2. No iodine contrast studies within 6 months prior to this exam.
3. No thyroid medication for 3 weeks prior to this exam.

NUCLEAR HIDA SCAN

Nothing to eat, drink or chew 6 hours prior to the procedure.

G.I SERIES AND/OR SMALL BOWEL

Nothing to eat, drink or chew 12 hours prior to the procedure.

VIRTUAL COLONOSCOPY/BARIUM ENEMA

Two days before the procedure, follow the direction for the 48-hour preparation in the FLEET BARIUM ENEMA KIT #3. This kit is available in our office at no charge to the patient, or at a pharmacy for a nominal fee.

HYSTEROSALPINGOGRAM:

Call for appointment on the **first** day of menstruation.

DIRECTIONS TO PARK AVENUE RADIOLOGISTS, PC.

Park Avenue Radiologists, PC is located at 525 Park Avenue between 60th and 61st street. Take the 4,5,6,N,R and W trains to 59th Street and Lexington Ave. Walk one block west to Park Avenue. Take F train to 63rd and Lexington Avenue. Walk one block west to Park Ave. and south to 61st. The office is on the east side of Park Ave. There is also a southbound Lexington Avenue bus and Northbound Madison Avenue bus. Parking garages are located on 60th St.. Between Lexington and Park Avenues and on 61st. between Park and Madison Avenues.