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Jay Lerman, MD
 Board Certified Radiologist
 MRI • Ultrasound
 Mammography • Cat Scan
 X-Ray • Bone Densitometry
 PET/CT

PATIENT'S NAME	APPT. DATE	APPT. TIME	PATIENT'S PHONE (H) (W)
REFERRING PHYSICIAN'S NAME & ADDRESS			PHYSICIAN'S PHONE (EXT.)
DIAGNOSIS (Reason for Testing) and Comments / Special Remarks			

CHECK PROCEDURE(S) REQUESTED

MAGNETIC RESONANCE IMAGING			MRI SCREENING										
<input type="checkbox"/> HEAD (Gen. Study) <input type="checkbox"/> IAC's <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> Posterior Fossa <input type="checkbox"/> Sinuses <input type="checkbox"/> TMJ <input type="checkbox"/> MR CHLORANGIOGRAPHY <input type="checkbox"/> MR VENOGRAPHY <input type="checkbox"/> Brain <input type="checkbox"/> Pelvis <input type="checkbox"/> Lower Ext	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> NECK (Soft Tissue) <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS <input type="checkbox"/> BRACHIAL PLEXUS EXTREMITY: L R Bilat <input type="checkbox"/> KNEE <input type="checkbox"/> SHOULDER <input type="checkbox"/> ANKLE <input type="checkbox"/> WRIST <input type="checkbox"/> HIP <input type="checkbox"/> OTHER JOINT Specify _____	<input type="checkbox"/> MR ANGIOGRAPHY <input type="checkbox"/> Carotids <input type="checkbox"/> Circle of Willis <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Lower Ext. <input type="checkbox"/> Other	SHRAPNEL <table border="1"><tr><td>Y</td><td>N</td></tr></table> METALLIC IMPLANTS <table border="1"><tr><td>Y</td><td>N</td></tr></table> PATIENT PREGNANT <table border="1"><tr><td>Y</td><td>N</td></tr></table> CARDIAC PACEMAKER <table border="1"><tr><td>Y</td><td>N</td></tr></table> ANEURYSM CLIP IN BRAIN <table border="1"><tr><td>Y</td><td>N</td></tr></table>	Y	N	Y	N	Y	N	Y	N	Y	N
Y	N												
Y	N												
Y	N												
Y	N												
Y	N												
CONTRAST <input type="checkbox"/> Please indicate below if you wish to use contrast when indicated but not ordered. <input type="checkbox"/> Yes <input type="checkbox"/> Please call first			*SEDATION FOR MRI PATIENTS WILL BE PROVIDED AS NECESSARY. <input type="checkbox"/> CHECK HERE IF SEDATION IS CONTRAINDICATED.										

CT SCANNING			CT SCREENING												
<input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS <input type="checkbox"/> NECK (Soft Tissue) <input type="checkbox"/> CT ANGIOGRAPHY <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Thoracic Aorta <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Carotids Other (specify) _____	<input type="checkbox"/> HEAD <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> LUMBOSACRAL SPINE <input type="checkbox"/> THORACIC SPINE Specify Level: _____	<input type="checkbox"/> NON-CONTRAST <input type="checkbox"/> CONTRAST Bun _____ Creatinine _____ Please indicate below if you wish to use contrast when indicated but not ordered. <input type="checkbox"/> Yes <input type="checkbox"/> Please call first												
			PATIENT PREGNANT <table border="1"><tr><td>Y</td><td>N</td></tr></table> ALLERGIC TO CONTRAST <table border="1"><tr><td>Y</td><td>N</td></tr></table> OTHER ALLERGIES <table border="1"><tr><td>Y</td><td>N</td></tr></table> ASTHMA <table border="1"><tr><td>Y</td><td>N</td></tr></table> HEART/KIDNEY DISORDER <table border="1"><tr><td>Y</td><td>N</td></tr></table> MYELOMA/DIABETES <table border="1"><tr><td>Y</td><td>N</td></tr></table>	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Y	N														
Y	N														
Y	N														
Y	N														
Y	N														
Y	N														
			SPECIAL INSTRUCTIONS												

PET/CT NUCLEAR	FLUOROSCOPY/ DIAGNOSTIC X-RAY
<input type="checkbox"/> ONCOLOGY TYPE _____ <input type="checkbox"/> NEUROLOGIC <input type="checkbox"/> SOLITARY PULMONARY NODULES <input type="checkbox"/> MYOCARDIAL VIABILITY <input type="checkbox"/> OTHER _____	<input type="checkbox"/> PLEASE INDICATE PROCEDURE

SONOGRAPHY			
<input type="checkbox"/> ABDOMINAL <input type="checkbox"/> RENAL <input type="checkbox"/> AORTA <input type="checkbox"/> PELVIC <input type="checkbox"/> TRANSVAGINAL <input type="checkbox"/> OBSTETRIC	<input type="checkbox"/> COLOR DOPPLER <input type="checkbox"/> CAROTID <input type="checkbox"/> LIVER <input type="checkbox"/> VENOUS <input type="checkbox"/> GYN <input type="checkbox"/> OTHER _____	<input type="checkbox"/> BREAST (L) or (R) <input type="checkbox"/> THYROID <input type="checkbox"/> GALL BLADDER <input type="checkbox"/> KIDNEYS <input type="checkbox"/> TESTES <input type="checkbox"/> OTHER _____	

DEXA BONE DENSITOMETRY	PRIOR IMAGING STUDIES OF THE ANATOMIC REGION OF INTEREST SHOULD ACCOMPANY PATIENT FOR COMPARISON
<input type="checkbox"/> LS SPINE <input type="checkbox"/> PELVIS <input type="checkbox"/> FOREARM <input type="checkbox"/> ROUTINE	<input type="checkbox"/> Call Stat Report <input type="checkbox"/> Phone Report <input type="checkbox"/> Patient to Return with Films
MAMMOGRAPHY (Low Dose)	
<input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL L R <input type="checkbox"/> <input type="checkbox"/>	