

Columbia-Presbyterian Eastside Radiology
16 East 60th Street
New York, New York 10022
(212) 326-5552 FAX: (212) 326-5555

SCHEDULING:

Patient's Name _____ UNIT # _____
 Clinical Information _____

Pre-Certification #

Please fax any special instructions to **212-326-5555**

MRI CONTRAST: WITH & WITHOUT WITH WITHOUT

- | | | | |
|------------------------------------|-----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Neck | <input type="checkbox"/> C-Spine | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Breast | <input type="checkbox"/> T-Spine | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Abdomen | <input type="checkbox"/> L-Spine | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Pelvis | <input type="checkbox"/> TMJ's | <input type="checkbox"/> Knee |
| <input type="checkbox"/> IAC's | <input type="checkbox"/> Prostate | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Ankle |

MRA

- Brain
 Carotids
 Aorta/Extremity
 Other _____

CT CONTRAST: WITH & WITHOUT WITH WITHOUT

- | | | | |
|---|-----------------------------------|--|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Neck | <input type="checkbox"/> CT Angiogram | <input type="checkbox"/> C-Spine _____ |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Chest | <input type="checkbox"/> CT Myelogram | <input type="checkbox"/> T-Spine _____ |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Lung Screening | <input type="checkbox"/> L-Spine _____ |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Coronary Artery Scoring | |
| <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Dentascan | <input type="checkbox"/> Other _____ |

ULTRASOUND

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Lower Extremity Venous Doppler | <input type="checkbox"/> Pelvic complete
(includes transvaginal) |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Transvaginal only |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Obstetrical | <input type="checkbox"/> Pelvic - Without transvaginal |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Testicular/Scrotal | |
| <input type="checkbox"/> Carotid Duplex | <input type="checkbox"/> Hysterosonography | <input type="checkbox"/> Other _____ |

BONE DENSITY

- Complete assessment (DEXA & compression fracture assessment)
 Only DEXA

CONVENTIONAL X-RAY & FLUOROSCOPY:

Please indicate procedure _____

MAMMOGRAPHY

- Bilat Screening: Routine; no problem
 Unilat: R or L Diagnostic: Maybe lump, focal pain, fibrocystic, cancer
 Ultrasound if indicated due to mammogram

NUCLEAR MEDICINE

- | | | |
|---|---|---|
| <input type="checkbox"/> Bone - Whole body | <input type="checkbox"/> Renal | <input type="checkbox"/> Gallium |
| <input type="checkbox"/> Bone - Three-phase | <input type="checkbox"/> Renal with Captopril | <input type="checkbox"/> SPECT for tumor |
| <input type="checkbox"/> MUGA | <input type="checkbox"/> Testicular | <input type="checkbox"/> SPECT for inflammation |
| <input type="checkbox"/> Hepatobiliary | <input type="checkbox"/> VCU | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Liver- Spleen | <input type="checkbox"/> Brain | |
| <input type="checkbox"/> Other _____ | | |

Requested by

Dr _____ Phone _____

Appointment Day _____ Time _____

Films Requested Yes No Film to (address) _____

Fax Report Yes No Fax # _____

PREPARATION FOR DIAGNOSTIC EXAMINATIONS

(WHEN MAKING YOUR APPOINTMENT, PLEASE INFORM THE OFFICE IF YOU ARE PREGNANT AND CONSULT YOUR PRIMARY PHYSICIAN)

MAGNETIC RESONANCE IMAGING (MRI):

1. You cannot have an MRI if you have a **CARDIAC PACEMAKER** or **BRAIN ANEURYSM CLIPS** or **STAPLES** (Middle Ear) **PROSTHESIS**.
2. **DO NOT WEAR EYE MAKE-UP.**
3. **YOU WILL HAVE TO REMOVE JEWELRY, HAIR PINS AND OTHER METALLIC ACCESSORIES FOR THE EXAM.**

CAT SCAN OF HEAD OR BODY WITH CONTRAST:

1. Nothing to eat, drink or chew 3 hours prior to exam.

CT MYELOGRAM:

1. Nothing to eat or drink 4 hours prior to exam.

ULTRASOUND:

ABDOMINAL:

1. Nothing to eat, drink or chew 12 hours prior to exam.

PELVIC:

1. 1 1/2 hours before appointment, empty bladder. You should not urinate again until after the exam.
2. Drink three 8oz. glasses of water and be finished drinking 1 hour before the appointment.
3. See receptionist if you feel you must urinate prior to the exam.

NUCLEAR HIDA SCAN:

1. Nothing to eat, drink or chew 12 hours prior to exam.

MAMMOGRAM:

Do not wear deodorant, power or lotion on the breast or underarm area. If available, bring old mammogram films with you for comparison.

G.I. SERIES AND/OR SMALL BOWEL:

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

BARIUM ENEMA WITH/WITHOUT AIR:

2 Days Before:

Follow directions for the 48 Hour Preparation in **FLEET BARIUM ENEMA KIT #2**. This kit is available in our office at no charge to the patient, or at a pharmacy for a nominal fee.

GALLBLADDER SERIES:

1 Day Before:

1. For dinner, no dairy foods, fats, oils, fried foods, meat, pastry, etc. May have boiled vegetables, saltines, jelly, black coffee, fruits, juices, sodas.

IVP:

1. Nothing to eat or drink after midnight*.

* Medications may be taken with a small amount of water.

IF A PATIENT HAS DIABETES OR OTHER MEDICAL CONDITION WHICH PREVENTS FOLLOWING A PREPARATION, HE/SHE SHOULD CONSULT HIS/HER OWN DOCTOR.