SINAI HOSPITAL
a LifeBridge Health center

☐ **STAT Phone Report Needed**
Providers's Phone # _____

☐ **Send CD with patient**

Attention: You must present this form at time of exam.

_____/___/___/_____
Patient's Name (Last, First) DOB

_____ _____/_____/_____ AM PM
Pre-authorization/Notification Number Appointment

_____/_____ (_____) - _____ -_____
Referring Physician Name (PRINTED) **Referring Physician Signature (required)** **Physician's Contact #**

ULTRASOUND

_____ (diagnosis)
_____ (ICD-9 code)

☐ Abdomen
☐ Breast ☐Right ☐Left ☐Bilateral
☐ Breast Biopsy ☐Right ☐Left
☐ Carotid Doppler
☐ Kidney & Bladder
☐ Gallbladder
☐ Liver
☐ Pelvic & Transvaginal
☐ Scrotum/Testicle
☐ Soft Tissue/Other _____
☐ Thyroid
☐ Venous Duplex
☐ Upper Extremity R, L, Bil (circle one)
☐ Lower Extremity R, L. Bil (circle one)
☐ **Other Exam** _____

MRI/MRA

_____ (diagnosis)
_____ (ICD-9 code)

☐ With Contrast ☐ Without Contrast
☐ With & Without Contrast
BUN _____ GFR _____
CREATININE _____
Date of Lab Work _____/_____/____
☐ Abdomen
☐ Brachial Plexus ☐Left ☐Right ☐Bilateral
☐ Pelvis
☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine
☐ Extremity _____
☐ MRI Head/Brain
☐ MRI Knee ☐Right ☐Left
☐ MRA Abdomen
☐ **Other Exam** _____

CT/CTA

_____ (diagnosis)
_____ (ICD-9 code)

☐ With Contrast ☐ Without Contrast
☐ With & Without Contrast
BUN _____
CREATININE_____
Date of Lab Work ____/____/____
☐ Abdomen & Pelvis
☐ Brain
☐ Chest
☐ Extremity _____
☐ Head
☐ Orbits
☐ Sinus ☐ Limited ☐ Complete
☐ Spine (Specify) _____
☐ 3D CT _____
☐ CTA
☐ **Other Exam** _____

FLUOROSCOPY

_____ (diagnosis)
_____ (ICD-9 code)

☐ Barium Enema
☐ Esophagram
☐ Small Bowel Series
☐ UGI
☐ **Other Exam** _____

MAMMOGRAPHY

_____ (diagnosis)
_____ (ICD-9 code

☐ Diagnostic ☐Right ☐Left ☐Bilateral
☐ Screening (asymptomatic)
☐ **Other Exam** _____

NUCLEAR MEDICINE

_____ (diagnosis)
_____ (ICD-9 code)

☐ Bone Scan
☐ Lung Scan
☐ Gastric Emptying
☐ HIDA (Hepatobiliary) Scan
☐ Lymphoscintigraphy
☐ MUGA
☐ Myocardial Perfusion Study
☐ Renal Structure
☐ Renal Function
☐ Thyroid Scan & Uptake
☐ I-123 or ☐ I-131
☐ **Other Exam** _____

PET/CT & PET

_____ (diagnosis)
_____ (ICD-9 code

☐ Skull/Mid Thigh
☐ Whole Body
☐ **Other Exam** _____

General X-Ray

Walk-in basis only
_____ (diagnosis)
_____ (ICD-9 code

Exam _____

Comments:

Please call (410) 601-9729 to schedule your appointment. Monday thru Friday 8:00 a.m. – 4:00 p.m.
PET/CT appointments ONLY call (410) 601-0941 Monday thru Friday 8:00 a.m. – 4:00 p.m.
Completed forms can be faxed to Sinai Radiology Patient Registration (410) 601-7403