

# URBAN RADIOLOGY, P.C.

A PHYSICIAN OWNED AND OPERATED IMAGING FACILITY

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Medical Director



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DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ TEL \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ AUTH. # \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SPECIFIC CLINICAL HISTORY IS NECESSARY FOR BETTER DIAGNOSTIC EVALUATION**

HISTORY \_\_\_\_\_

| MRI  | CT SCAN   | GENERAL RADIOLOGY / X-RAY  |
|--|---|--|
| <p style="text-align: center;"><b>IV contrast</b></p> <p><input type="checkbox"/> Brain <input type="checkbox"/> 70551 <input type="checkbox"/> 53<br/> <input type="checkbox"/> Pituitary <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> IAC's <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> Orbits <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> Sinuses <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> Neck-Soft Tissue <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> 70540 <input type="checkbox"/> 43<br/> <input type="checkbox"/> TMJ Lt. Rt. <input type="checkbox"/> 70336<br/> <input type="checkbox"/> C-Spine <input type="checkbox"/> Myelography <input type="checkbox"/> 72141 <input type="checkbox"/> 56<br/> <input type="checkbox"/> T-Spine <input type="checkbox"/> Myelography <input type="checkbox"/> 72146 <input type="checkbox"/> 57<br/> <input type="checkbox"/> L-Spine <input type="checkbox"/> Myelography <input type="checkbox"/> 72148 <input type="checkbox"/> 58<br/> <input type="checkbox"/> Chest <input type="checkbox"/> 71550 <input type="checkbox"/> 52<br/> <input type="checkbox"/> Breast w/CAD Lt. Rt. <input type="checkbox"/> 77058 <input type="checkbox"/> 58<br/> <input type="checkbox"/> Breasts Bilateral w/CAD <input type="checkbox"/> 77059 <input type="checkbox"/> 59<br/> <input type="checkbox"/> Abdomen <input type="checkbox"/> MRCP <input type="checkbox"/> 74181 <input type="checkbox"/> 83<br/> <input type="checkbox"/> Pelvis <input type="checkbox"/> 72195 <input type="checkbox"/> 97</p> <p><b>Extremities</b></p> <p><input type="checkbox"/> Shoulder Lt. Rt. <input type="checkbox"/> 73221 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Elbow Lt. Rt. <input type="checkbox"/> 73221 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Wrist Lt. Rt. <input type="checkbox"/> 73221 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Hand Lt. Rt. <input type="checkbox"/> 73218 <input type="checkbox"/> 20<br/> <input type="checkbox"/> Hip Lt. Rt. <input type="checkbox"/> 73721 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Knee Lt. Rt. <input type="checkbox"/> 73721 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Ankle Lt. Rt. <input type="checkbox"/> 73721 <input type="checkbox"/> 23<br/> <input type="checkbox"/> Foot Lt. Rt. <input type="checkbox"/> 73718 <input type="checkbox"/> 20</p> <p><b>Other</b> _____</p> | <p style="text-align: center;"><b>IV contrast</b></p> <p><input type="checkbox"/> Head/Brain <input type="checkbox"/> 70450 <input type="checkbox"/> 70<br/> <input type="checkbox"/> Sinuses <input type="checkbox"/> 70486 <input type="checkbox"/> 88<br/> <input type="checkbox"/> Orbit/Ear <input type="checkbox"/> 70480 <input type="checkbox"/> 82<br/> <input type="checkbox"/> Chest <input type="checkbox"/> 71250 <input type="checkbox"/> 70<br/> <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> 70490 <input type="checkbox"/> 92<br/> <input type="checkbox"/> Abdomen <input type="checkbox"/> 74150 <input type="checkbox"/> 70<br/> <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> 74176 <input type="checkbox"/> 78<br/> <input type="checkbox"/> Pelvis <input type="checkbox"/> 72192 <input type="checkbox"/> 94<br/> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> 72125 <input type="checkbox"/> 27<br/> <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> 72128 <input type="checkbox"/> 30<br/> <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> 72131 <input type="checkbox"/> 33</p> <p><b>Extremities</b></p> <p><input type="checkbox"/> Shoulder Lt. Rt. <input type="checkbox"/> 73200 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Elbow Lt. Rt. <input type="checkbox"/> 73200 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Wrist Lt. Rt. <input type="checkbox"/> 73200 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Hand Lt. Rt. <input type="checkbox"/> 73200 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Hip Lt. Rt. <input type="checkbox"/> 73700 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Knee Lt. Rt. <input type="checkbox"/> 73700 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Ankle Lt. Rt. <input type="checkbox"/> 73700 <input type="checkbox"/> 02<br/> <input type="checkbox"/> Foot Lt. Rt. <input type="checkbox"/> 73700 <input type="checkbox"/> 02</p> <p><b>Other</b> _____</p> | <p><input type="checkbox"/> Skull<br/> <input type="checkbox"/> Orbits Rt. Lt.<br/> <input type="checkbox"/> Facial Bones<br/> <input type="checkbox"/> Nasal Bones<br/> <input type="checkbox"/> Paranasal Sinuses<br/> <input type="checkbox"/> Nasopharynx/NeckSoft Tissue<br/> <input type="checkbox"/> Cervical Spine<br/> <input type="checkbox"/> Cervical Spine w/Obliques<br/> <input type="checkbox"/> Thoracic Spine<br/> <input type="checkbox"/> Lumbar Spine<br/> <input type="checkbox"/> Lumbar Spine w/Obliques<br/> <input type="checkbox"/> Pelvis<br/> <input type="checkbox"/> Sacrum/Coccyx<br/> <input type="checkbox"/> SI Joints<br/> <input type="checkbox"/> Shoulder Rt. Lt.<br/> <input type="checkbox"/> Clavicle Rt. Lt.<br/> <input type="checkbox"/> Chest PA/LAT<br/> <input type="checkbox"/> Ribs Rt. Lt.<br/> <input type="checkbox"/> Sternum<br/> <input type="checkbox"/> Arm/Humerus Rt. Lt.<br/> <input type="checkbox"/> Elbow Rt. Lt.<br/> <input type="checkbox"/> Forearm Rt. Lt.<br/> <input type="checkbox"/> Wrist Rt. Lt.<br/> <input type="checkbox"/> Hand Rt. Lt.<br/> <input type="checkbox"/> Finger Rt. Lt.<br/> <input type="checkbox"/> Abdomen/Pelvis (KUB)<br/> <input type="checkbox"/> Abdomen-Flat/Upright<br/> <input type="checkbox"/> Hip Rt. Lt.<br/> <input type="checkbox"/> Femur Rt. Lt.<br/> <input type="checkbox"/> Knee Rt. Lt.<br/> <input type="checkbox"/> Tibia/Fibula Rt. Lt.<br/> <input type="checkbox"/> Ankle Rt. Lt.<br/> <input type="checkbox"/> Heel/Calcaneous Rt. Lt.<br/> <input type="checkbox"/> Foot Rt. Lt.<br/> <input type="checkbox"/> Toe Rt. Lt.</p> <p><b>Other</b> _____</p> |
| <p style="text-align: center;"><b>MRA</b></p> <p><b>MR Angiography</b> <span style="float: right;"><b>IV contrast</b></span></p> <p><input type="checkbox"/> MRA Head/Brain <input type="checkbox"/> 70544 <input type="checkbox"/> 46<br/> <input type="checkbox"/> MRA Neck/Carotid <input type="checkbox"/> 70547 <input type="checkbox"/> 49<br/> <input type="checkbox"/> MRA Thoracic Aorta <input type="checkbox"/> 71555 <input type="checkbox"/> 55<br/> <input type="checkbox"/> MRA Chest <input type="checkbox"/> 71555 <input type="checkbox"/> 55<br/> <input type="checkbox"/> MRA Abdominal Aorta <input type="checkbox"/> 74185 <input type="checkbox"/> 85<br/> <input type="checkbox"/> MRA Renal/Pelvis <input type="checkbox"/> 72198 <input type="checkbox"/> 98<br/> <input type="checkbox"/> MRA Upper Extremities <input type="checkbox"/> 73225 <input type="checkbox"/> 25<br/> <input type="checkbox"/> MRA Lower Extremities<br/>             &amp; MRA Abd. Aorta<br/>             &amp; MRA Renal/Pelvis <input type="checkbox"/> 73725/74185/72198</p> <p><b>Other</b> _____</p>   | <p style="text-align: center;"><b>SONOGRAPHY</b></p> <p><input type="checkbox"/> Abdomen c̄ Color Doppler <input type="checkbox"/> 76700<br/> <input type="checkbox"/> Pelvis c̄ Color Doppler <input type="checkbox"/> 76856<br/> <input type="checkbox"/> Retroperitoneum c̄ Color Doppler <input type="checkbox"/> 76770<br/> <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> 93978<br/> <input type="checkbox"/> Fem. Pelvis/Transabdominal/Transvaginal c̄ Doppler <input type="checkbox"/> 76856/76830<br/> <input type="checkbox"/> OB Sono 1st Trimester c̄ Doppler <input type="checkbox"/> 76801<br/> <input type="checkbox"/> Testicular c̄ Doppler Analysis <input type="checkbox"/> 76870<br/> <input type="checkbox"/> Male Pelvis/TransAbdominal c̄ Doppler <input type="checkbox"/> 76872<br/> <input type="checkbox"/> Neck Soft Tissue (thyroid/carotid) <input type="checkbox"/> 76536<br/> <input type="checkbox"/> Breast <input type="checkbox"/> 76645<br/> <input type="checkbox"/> Carotid Arteries <input type="checkbox"/> 93880<br/> <input type="checkbox"/> Lower Extremity Arteries <input type="checkbox"/> 93925<br/> <input type="checkbox"/> Upper Extremity Arteries <input type="checkbox"/> 93930<br/> <input type="checkbox"/> Duplex of Extremity Veins <input type="checkbox"/> 93970<br/> <input type="checkbox"/> Duplex of Arterial Inflow/Venous Outflow <input type="checkbox"/> 93975</p> <p><b>Other</b> _____</p>  | <p style="text-align: center;"><b>DIGITAL MAMMOGRAPHY W/CAD</b></p> <p><input type="checkbox"/> Screening<br/> <input type="checkbox"/> Diagnostic Rt. Lt.<br/>             (Spot Compression)</p>   |
| <p style="text-align: center;"><b>CTA</b></p> <p><b>CT Angiography</b> Available at locations noted with <b>w+w/o</b></p> <p><input type="checkbox"/> CTA Head Intracranial Vessels <input type="checkbox"/> 70496<br/> <input type="checkbox"/> CTA Neck Carotid <input type="checkbox"/> 70498<br/> <input type="checkbox"/> CTA Chest <input type="checkbox"/> 71275<br/> <input type="checkbox"/> CTA Abdominal Aorta <input type="checkbox"/> 74175<br/> <input type="checkbox"/> CTA Pelvis <input type="checkbox"/> 72191<br/> <input type="checkbox"/> CTA Upper Extremities <input type="checkbox"/> 73206<br/> <input type="checkbox"/> CTA Lower Extremities &amp; CTA Abd. Aorta<br/>             &amp; CTA Renal/Pelvis <input type="checkbox"/> 73706/74175/72191</p> <p><b>Other</b> _____</p>  | <p style="text-align: center;"><b>SIMPLANT DENTAL CT</b></p> <p><input type="checkbox"/> Maxilla <input type="checkbox"/> Maxilla &amp; Mandible <input type="checkbox"/> Single Tooth _____<br/> <input type="checkbox"/> Mandible <input type="checkbox"/> Quadrant _____</p> <p><b>Other</b> _____</p>   | <p style="text-align: center;"><b>DEXA</b></p> <p><input type="checkbox"/> Bone Densitometry with<br/>             Vertebral Fracture<br/>             Assessment</p>  |
|  |   | <p style="text-align: center;"><b>ECHOCARDIOGRAPHY</b></p> <p><input type="checkbox"/> Echocardiography (2D) c̄ Color<br/>             Doppler &amp; Velocity Mapping</p>  |