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 East Patchogue, New York 11772
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 www.suffolkmri.com

Diagnostic Imaging Services
Patient Referral

OPEN MRI &
 NUCLEAR MEDICINE
 Smithtown 631-864-9100

Patient Name _____ Date _____

Clinical Indications _____

Special Instructions _____

Referring Dr. _____ Copy of Films Requested Y N

MRI SCAN 1.5T SHORT BORE

- | | | |
|---|---|---|
| <input type="checkbox"/> Brain
<input type="checkbox"/> With Contrast
<input type="checkbox"/> MR Spectroscopy
<input type="checkbox"/> Diffusion
<input type="checkbox"/> Perfusion
<input type="checkbox"/> IACs
<input type="checkbox"/> Orbits
<input type="checkbox"/> Neck (Soft Tissue)
<input type="checkbox"/> Pituitary
<input type="checkbox"/> TMJs
<input type="checkbox"/> Spine
<input type="checkbox"/> Cervical
<input type="checkbox"/> Thoracic
<input type="checkbox"/> Lumbar
<input type="checkbox"/> With Contrast | <input type="checkbox"/> MR Angiography
<input type="checkbox"/> Carotid
<input type="checkbox"/> Cerebral
<input type="checkbox"/> Other _____
<input type="checkbox"/> MR Angiography with Contrast
<input type="checkbox"/> Aorta
<input type="checkbox"/> Renals
<input type="checkbox"/> Lower Extremities
<input type="checkbox"/> Carotid
<input type="checkbox"/> Other _____
<input type="checkbox"/> Upper Extremities Joint
<input type="checkbox"/> Shoulder R / L
<input type="checkbox"/> Elbow R / L
<input type="checkbox"/> Wrist R / L
<input type="checkbox"/> Upper Extremity Soft Tissue
<input type="checkbox"/> Hand/Finger R / L | <input type="checkbox"/> Lower Extremity Foot
<small>(midfoot - forefoot)</small> R / L
<input type="checkbox"/> Lower Extremity Joint
<input type="checkbox"/> Ankle <small>(midfoot - forefoot)</small> R / L
<input type="checkbox"/> Hip R / L
<input type="checkbox"/> Knee R / L
<input type="checkbox"/> Abdomen
<input type="checkbox"/> Liver
<input type="checkbox"/> Kidney
<input type="checkbox"/> MRCP
<input type="checkbox"/> Pelvis
<input type="checkbox"/> Chest
<input type="checkbox"/> MR Mammography
<input type="checkbox"/> Other _____ |
|---|---|---|

Contraindications: Cardiac Pacemaker, Spinal Cord Stimulator, Cerebral Aneurysm Clip, Ear Implant, Metallic Fragments in Eye, Drug Infusion Pump, Cardiac Defibrillator, Pregnancy.

CT SCAN (MULTISLICE) Oral Contrast IV Contrast Bun _____ Creatinine _____ 50 & Over

- | | | |
|---|---|---|
| <input type="checkbox"/> Brain
<input type="checkbox"/> Temporal Bone
<input type="checkbox"/> Orbits
<input type="checkbox"/> Sinuses
<input type="checkbox"/> Neck (Soft Tissue)
<input type="checkbox"/> Chest
<input type="checkbox"/> Abdomen
<input type="checkbox"/> Pelvis
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Spine
<input type="checkbox"/> Cervical
<input type="checkbox"/> Thoracic (Levels: _____)
<input type="checkbox"/> Lumbar
<input type="checkbox"/> Sacrum
<input type="checkbox"/> Spine 3D Imaging
Vertebral Levels: _____
<input type="checkbox"/> Orthopedic CT 3D Imaging
Joint _____ | <input type="checkbox"/> CT Angiography
<input type="checkbox"/> Carotid
<input type="checkbox"/> Cerebral
<input type="checkbox"/> Aorta
<input type="checkbox"/> Renal
<input type="checkbox"/> Lower Extremity
<input type="checkbox"/> Other _____ |
|---|---|---|

ULTRASOUND

- Abdomen Transvaginal
 Pelvis Thyroid
 Renal Aorta

- Reflux Study
 Other _____

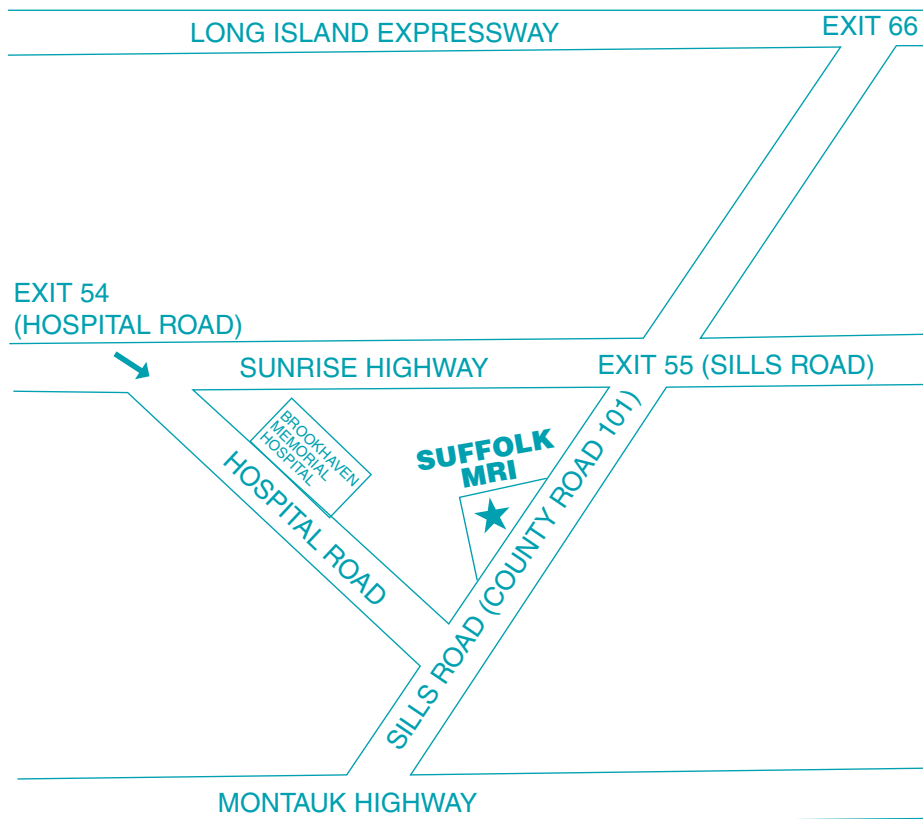
DOPPLER

- Carotid
 Renal
 Other _____

- Extremity Venous Study** R L

GENERAL RADIOLOGY – Please circle R (right) or L (left) if applicable

- | | | | | |
|---------------------------------------|--------------------------------------|---|--|---|
| <input type="checkbox"/> Skull | <input type="checkbox"/> L Spine | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Wrist R / L | <input type="checkbox"/> Tibia/Fibula R / L |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Sacrum | <input type="checkbox"/> Bone Age | <input type="checkbox"/> Hand R / L | <input type="checkbox"/> Ankle R / L |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Chest | <input type="checkbox"/> Shoulder R / L | <input type="checkbox"/> Fingers R / L | <input type="checkbox"/> Foot R / L |
| <input type="checkbox"/> Nasal Bones | <input type="checkbox"/> Ribs R / L | <input type="checkbox"/> Humerus R / L | <input type="checkbox"/> Hip R / L | <input type="checkbox"/> Toes R / L |
| <input type="checkbox"/> C Spine | <input type="checkbox"/> F/U Abdomen | <input type="checkbox"/> Elbow R / L | <input type="checkbox"/> Femur R / L | |
| <input type="checkbox"/> T Spine | <input type="checkbox"/> KUB Abdomen | <input type="checkbox"/> Forearm R / L | <input type="checkbox"/> Knee R / L | |
| <input type="checkbox"/> Other _____ | | | | |



TAKE EXIT 55 SOUTH OFF SUNRISE HIGHWAY OR
EXIT 66 SOUTH FROM THE L.I.E

EXAM PREPARATION

MRI

Wear comfortable clothing that does not contain metal. Please do not wear jewelry or metal hair clips, pins or eye makeup. If you have a **pacemaker**, **aneurysm clip**, or **ear implant** an MRI can **NOT** be performed.

CT

When scheduling your appointment the facility will advise what preparation to follow.

IF YOU ARE PREGNANT NOTIFY OUR OFFICE WHEN SCHEDULING YOUR APPOINTMENT.