DANIEL SCHLUSSELBERG M.D. P.C.

Service Location – 260 Rt 303, West Nyack, NY 10994
Tel. (845) 271-2111 Fax (888) 673-5656

Please call (845) 271-2111 to schedule your appointment!

Por favor llame al (845) 271-2111 para aser una cita!

Patient's Name _____ Date _____

Patient's Address _____ Tel. _____

Patient's Insurance _____ Authorization _____

Referring Physician _____ Tel. _____

Diagnosis _____ revealed during initial / follow-up exam dated _____

Ruling Out _____ Is that an emergency service? ❑ Y ❑ N

If multiple diagnostic procedures are prescribed how many can be done per visit due to patient medical condition _____

PRECAUTIONS

Currently Pregnant	❑ yes	❑ no
Metallic Implants	❑ yes	❑ no
Aneurysm Brain Clip	❑ yes	❑ no
Shrapnel (Metal in Body)	❑ yes	❑ no
Cardiac Pacemaker	❑ yes	❑ no

By signing this referral I confirm reading and marking true and appropriate options in the above precautions, as well as consent to contrast procedure (if prescribed).

I am familiar with various local diagnostic facilities. It is my own choice and decision to have the imaging service done by Daniel Schlusselberg M.D. P.C.

I agree that my signature and date can serve as a proof of my diagnostic exam performed at Daniel Schlusselberg M.D. P.C.

on ____/____/____.

Patient's Signature _____

On the date of your exam do not wear jewelry, metal hair clips or any other clothing metal accessories. Patient must bring picture ID and Insurance card at time of appointment.

Appt. Day _____ Time _____ ❑ AM ❑ PM

_____

Referring Doctor Signature

OPEN MRI

	Check for Contrast		Left	Right
❑ Brain	❑	❑ Shoulder	❑	❑
❑ Posterior Fossa	❑	❑ Elbow	❑	❑
❑ Pituitary	❑	❑ Wrist	❑	❑
❑ Orbits	❑	❑ Hand	❑	❑
❑ Internal Auditory Canal	❑	❑ Hip	❑	❑
❑ Cervical Spine	❑	❑ Knee	❑	❑
❑ Thoracic Spine	❑	❑ Ankle	❑	❑
❑ Lumbar Spine	❑	❑ Foot	❑	❑
❑ Chest	❑	❑ T.M.J.	❑	❑
❑ Abdomen ❑ Pelvis	❑	❑ Other _____	❑	❑
❑ MRA Circle of Willis	❑	❑ MRA Carotid arteries	❑	❑

If MRI with contrast please specify:
❑ Oral only ❑ IV only ❑ Oral+IV

X-RAY

EXTREMITIES	Left	Right
❑ Shoulder	❑	❑
❑ Scapula	❑	❑
❑ Clavicle	❑	❑
❑ Humerus	❑	❑
❑ Elbow	❑	❑
❑ Forearm	❑	❑
❑ Wrist	❑	❑
❑ Hand	❑	❑
❑ Hip	❑	❑
❑ Femur	❑	❑
❑ Knee	❑	❑
❑ Tibia & Fibula	❑	❑
❑ Ankle	❑	❑
❑ Foot	❑	❑
❑ Other _____	❑	❑

SPINE
❑ Complete
❑ Cervical
❑ Dorsal
❑ Lumbar
❑ Pelvis
❑ Sacrum & Coccyx

CHEST
❑ Chest
❑ Unilat. Ribs
❑ Bilateral Ribs
❑ Sternum
❑ Chest Flouroscopy
❑ Other _____

HEAD and NECK
❑ Skull
❑ Sinuses
❑ Nasal Bones
❑ Mastoids
❑ Orbits
❑ T.M. Joints
❑ Zygomatic Arches
❑ Other _____