



LEADING EDGE

Medical Diagnostic P.C.



290 Broadway, Ste. 1, Newburgh, NY 12550
Tel. (845) 562-4545 Fax (845) 689-0613 www.leadingedgemedicalpc.com

**Please call (845) 562-4545
to schedule your appointment!**

**Por favor llame al (845) 562-4545
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	<input type="checkbox"/> yes	<input type="checkbox"/> no
Metallic Implants	<input type="checkbox"/> yes	<input type="checkbox"/> no
Aneurysm Brain Clip	<input type="checkbox"/> yes	<input type="checkbox"/> no
Shrapnel (Metal in Body)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cardiac Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> 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 Leading Edge Medical Diagnostic P.C.

I agree that my signature and date can serve as a proof of my diagnostic exam performed at Leading Edge 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.

OPEN MRI

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

If MRI with contrast please specify:

☐ Oral only ☐ IV only ☐ Oral+IV

X-RAY

EXTREMITIES

	Left	Right
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Scapula	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clavicle	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Humerus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Femur	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tibia & Fibula	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

SPINE

☐ Complete
☐ Cervical
☐ Dorsal
☐ Lumbar
☐ Pelvis
☐ Sacrum & Coccyx

Appt. Day _____ Time _____ ☐ AM ☐ PM

Referring Doctor Signature _____