

MARINE PARK RADIOLOGY, P.C.

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Board Certified Radiologists

PATIENT'S NAME _____ DRS. PHONE _____

REFERRING DOCTOR _____ DRS. FAX _____

DR's SIGNATURE _____ APPT. DATE _____ APPT. TIME _____

CLINICAL HISTORY (PLEASE INCLUDE BUN & CREATININE FOR CT CONTRAST INJECTIONS)

SPECIAL INSTRUCTIONS _____

Effective January 1st 2015, all referral slips must be signed by referring Doctor. Stamped signatures are no longer acceptable.

OPEN MRI/MRA (ICAMRL ACCREDITED)

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> BRAIN | <input type="checkbox"/> ORBITS | <input type="checkbox"/> CHEST | <input type="checkbox"/> MRA |
| <input type="checkbox"/> PITUITARY | <input type="checkbox"/> NECK (SOFT TISSUE) | <input type="checkbox"/> ABDOMEN | Specify _____ |
| <input type="checkbox"/> IAC | <input type="checkbox"/> CERVICAL SPINE | <input type="checkbox"/> PELVIS | <input type="checkbox"/> CONTRAST <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> POSTERIOR FOSSA | <input type="checkbox"/> THORACIC SPINE | <input type="checkbox"/> JOINTS/ | <input type="checkbox"/> CONTRAST TO BE |
| <input type="checkbox"/> SINUSES | <input type="checkbox"/> LUMBAR SPINE | <input type="checkbox"/> EXTREMITIES | DECIDED BY RAD |
| | | | <input type="checkbox"/> OTHER _____ |

CT SCAN (HIGH SPEED SPIRAL) (ACR ACCREDITED)

- | | | | |
|---------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> BRAIN | <input type="checkbox"/> TMJ | <input type="checkbox"/> BONY PELVIS | <input type="checkbox"/> JOINTS/EXTREMITIES |
| <input type="checkbox"/> IAC | <input type="checkbox"/> NECK (SOFT TISSUE) | <input type="checkbox"/> CHEST | <input type="checkbox"/> CONTRAST <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> FACIAL BONES | <input type="checkbox"/> CERVICAL SPINE | <input type="checkbox"/> ABDOMEN | <input type="checkbox"/> CONTRAST TO BE |
| <input type="checkbox"/> SINUSES | <input type="checkbox"/> THORACIC SPINE | <input type="checkbox"/> PELVIS | DECIDED BY RAD |
| <input type="checkbox"/> ORBITS | <input type="checkbox"/> LUMBAR SPINE | <input type="checkbox"/> UROGRAM | <input type="checkbox"/> OTHER _____ |

ULTRASOUND (ACR ACCREDITED FOR OB, GENERAL & VASCULAR)

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> ABDOMEN | <input type="checkbox"/> ARTERIAL DOPPLER | <input type="checkbox"/> OB | <input type="checkbox"/> RENAL |
| <input type="checkbox"/> AORTA | <input type="checkbox"/> Uni. <input type="checkbox"/> Bil. | <input type="checkbox"/> OB/BIOPHYSICAL | <input type="checkbox"/> TESTICULAR |
| <input type="checkbox"/> BLADDER | <input type="checkbox"/> CAROTID DOPPLER | <input type="checkbox"/> PELVIS | <input type="checkbox"/> THYROID |
| <input type="checkbox"/> BREAST | <input type="checkbox"/> VENOUS DOPPLER | <input type="checkbox"/> PROSTATE/TRANSRECTAL | <input type="checkbox"/> TRANSVAGINAL |
| <input type="checkbox"/> Uni. <input type="checkbox"/> Bil. | <input type="checkbox"/> Uni. <input type="checkbox"/> Bil. | | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> RENAL DOPPLER | | OTHER |
| | <input type="checkbox"/> DOPPLER OTHER _____ | | |

DIGITAL MAMMOGRAPHY (ACR ACCREDITED)

- | | | | |
|------------------------------------|-------------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> BILATERAL | <input type="checkbox"/> UNILATERAL | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT |
|------------------------------------|-------------------------------------|--------------------------------|-------------------------------|

GENERAL RADIOLOGY DIGITAL

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> FACIAL BONES | <input type="checkbox"/> CERVICAL SPINE | <input type="checkbox"/> DEXA with IVA |
| <input type="checkbox"/> SKULL | <input type="checkbox"/> THORACIC SPINE | <input type="checkbox"/> _____ |
| <input type="checkbox"/> SINUS | <input type="checkbox"/> LUMBAR SPINE | OTHER |
| <input type="checkbox"/> CHEST | <input type="checkbox"/> ABDOMEN | |
| <input type="checkbox"/> RIBS | <input type="checkbox"/> PELVIS | |
| <input type="checkbox"/> EXTREMITY | <input type="checkbox"/> BONE AGE | |

BRING ANY PREVIOUS REPORTS OR FILMS PERTAINING TO THE AREA OF EXAMINATION

SOME INFORMATION ABOUT YOUR VISIT TO MARINE PARK RADIOLOGY

At Marine Park Radiology, we want to make your visit as convenient and comfortable as possible. **We do ask that you arrive 15 minutes before your appointment** in order to complete any paperwork needed for billing. You may be able to be seen prior to your appointment. Sometimes there are emergencies which require immediate attention. This could cause a delay in being taken on time and we do ask your understanding.

PREPARATION FOR STUDY

CT Scan (Spiral)	Have nothing to eat, drink, smoke or chew (except medication) for 4 hours before CT scan of brain, neck, abdomen or pelvis. Fasting is not necessary before a spinal CT scan.
DEXA	NO CALCIUM SUPPLEMENTS FOR 24 HOURS PRIOR TO TEST. Wear loose, comfortable clothing. NO METAL BUTTONS, ZIPPERS, SNAPS OR UNDERWIRE BRA. Pt can change into a gown if needed.
Open MRI/MRA	Wear clothing with no metal zippers, buttons, snaps etc. (jogging suit is excellent). Wear no jewelry or eye mascara. MRI IS CONTRAINDICATED IN PATIENTS WITH PACEMAKERS, SOME EAR IMPLANTS AND MOST CEREBRAL ANEURYSM CLIPS.
Mammogram	Do not wear perfume, deodorant or talcum powder on breast or near underarm area on day of exam. Schedule routine exam for 5-12 days after period begins. Bring your previous mammogram films with you. If possible, gradually cut down caffeine consumption one week before appointment.
Ultrasound Pelvic or OB/GYN	A full bladder is necessary for the exam. Eat breakfast or lunch as usual. 90 minutes before exam empty your bladder, then drink 32 oz. of water within 30 minutes. DO NOT EMPTY BLADDER AGAIN.
Ultrasound Abdominal	Nothing to eat or drink 4 hours before the exam.
All other Testing	Report 15 minutes before appointed time.

OUR PAYMENT POLICY

Marine Park & Kings Plaza Radiology participate with many insurance plans, including Medicare. Please bring your insurance cards with you along with a referral or prescription. If we do not participate with your insurance company you will be responsible for the balance between your insurance company's payment and our charge. Authorization for Workers' Compensation and No Fault Motor Vehicle Accidents should be given to us upon your arrival. Remember, if your insurance company requires referral forms you must bring it with you in order to have the test.

DIRECTIONS - We are on Kimball St. between Avenues U and V in Kings Plaza Professional Building's lower level. Convenient ramp entrance and elevator access from parking lot. **If you are scheduled for a test and have transportation difficulties please call the center for assistance.**

BY CAR: Belt Parkway Exit 11N - Flatbush Ave. N. Take Flatbush Ave. to Ave. V (3 traffic lights). Make a left onto Ave. V, take Ave. V for 3 blocks and make a right on Kimball St. We are located on your left. See above.

BY TRAIN: Take B or Q trains to Kings Highway Station (use exit nearest to East 16th St.). Take the B2 bus to Kings Plaza Mall. Walk 3 blocks west. See above.

BY BUS: Take the B2, B3, B9, B41, B44 or B49 bus to the Kings Plaza Mall. Walk towards Avenues U or V. Walk 3 blocks to Kimball Street. See Above.

