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PATIENT NAME: _____ TEL #: _____

CLINICAL INFORMATION: _____

_____

_____ DATE: _____

PHYSICIAN NAME: _____

PHYSICIAN PHONE #: _____

GASTROENTEROLOGY REFERRAL FORM

MRI

1.5 T HIGH FIELD
IV CONTRAST*: ☐YES ☐NO

- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ PERINEUM
- ☐ MRCP
- ☐ MRI ATTN: LIVER
- ☐ MRI ATTN: PANCREAS
- ☐ OTHER .....

MRA ANGIOGRAM

- ☐ MESENTERIC
  - ☐ ARTERIAL
  - ☐ VENOUS
- ☐ AORTIC
- ☐ OTHER .....

CT SCAN 64 DETECTOR

IV CONTRAST*: ☐YES ☐NO
WE USE NON-IONIC CONTRAST MEDIA EXCLUSIVELY

- ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ CT SMALL BOWEL
- ☐ CT PREPPED COLON (AIR)
- ☐ CT BARIUM ENEMA
- ☐ CT GASTROGRAFFIN ENEMA
- ☐ VIRTUAL COLONOSCOPY (SCREENING)
- ☐ CT ATTN: PANCREAS
- ☐ CT ATTN: LIVER
- ☐ OTHER.....
- ☐ CT ANGIOGRAM
  - ☐ MESENTERIC ANGIOGRAM
    - ☐ ARTERIAL ☐ VENOUS
  - ☐ PULMONARY ANGIOGRAM

GENERAL RADIOLOGY

- ☐ DEXA
- ☐ CHEST
- ☐ OBSTRUCTIVE SERIES
- ☐ KUB
- ☐ MARKER STUDY
- ☐ OTHER.....

ULTRASOUND

- ☐ ABDOMEN
  - ☐ WITH DOPPLER
- ☐ PELVIS
  - ☐ WITH DOPPLER
- ☐ RIGHT LOWER QUADRANT
- ☐ RENAL
- ☐ SCROTAL
- ☐ OTHER.....

N.M. SCINTIGRAPHY

- ☐ HIDA SCAN ☐ GB EJECTION FRACTION
- ☐ LABELLED RED CELL (HEMANGIOMA)
- ☐ OCTREOTIDE
- ☐ MECKEL'S SCAN
- ☐ BONE SCAN
- ☐ OTHER.....
- ☐ PYE HELICOBACTER BREATH TEST
- ☐ LIVER (SULPHUR COLLOID SCAN)
- ☐ GASTRIC EMPTYING SCAN
- ☐ GALLIUM SCAN
- ☐ BLEEDING STUDY
- ☐ SPECT IMAGING

FLUOROSCOPY

- ☐ ESOPHAGRAM
- ☐ SMALL BOWEL SERIES
- ☐ FISTULOGRAM
- ☐ VIDEO - ESOPHAGRAM
- ☐ OTHER .....
- ☐ GI/SMALL BOWEL
- ☐ POUCHOGRAM
- ☐ GI SERIES
- ☐ BARIUM ENEMA
- ☐ GASTROGRAFFIN ENEMA

***IF PATIENT HAS AN ALLERGIC OR ASTHMATIC HISTORY OR IS DISABLED, PLEASE CALL (212) 535-9770 FOR INFORMATION.**

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