



Open MRI • MRA • Cat Scan (Spiral, Multislice)
Digital X-Ray • Bone Densitometry
Ultrasound • Mammography

ATLANTIC RADIOLOGY IMAGING, P.C.

"The New Imaging Reality"

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Certified, American Board of Nuclear Cardiology
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PLEASE OBTAIN NECESSARY AUTHORIZATION TO AVOID DELAYS

PATIENT'S NAME _____ DATE OF BIRTH _____ DATE _____

HISTORY _____

REASON FOR EXAM _____ REFERRING DOCTOR _____

Stat Examination Patient to Return with Films CD Phone # _____

MRI information: MRI is contraindicated in patients with Pacemakers, Ear Implants, Cerebral Aneurysm Clips and Metal in Eyes. Etc.

CT information: BUN _____ /CREATININE _____ Date of Blood Work _____

Asthma, Allergy or Diabetes needing contract, please alert our office when making your appointment.

OPEN MRI		
<input type="checkbox"/> Brain	w/o <input type="checkbox"/>	with &w/o <input type="checkbox"/>
<input type="checkbox"/> Pituitary	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IACs	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbits	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TMJ	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck-Soft Tissue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast	Rt. <input type="checkbox"/>	Lt. <input type="checkbox"/>
Extremities		
<input type="checkbox"/> Shoulder	Rt. <input type="checkbox"/>	Lt. <input type="checkbox"/>
<input type="checkbox"/> Elbow	<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"/> Knee	<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"/>
Angiography		
<input type="checkbox"/> Brain MRI (Circle of Willis)		
<input type="checkbox"/> Neck MRI (Carotid)		

SPIRAL CT MULTISLICE		
<input type="checkbox"/> Brain	w/o <input type="checkbox"/>	with &w/o <input type="checkbox"/>
<input type="checkbox"/> Pituitary	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbits	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporal Bones/IAC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck-Soft Tissue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental		
<input type="checkbox"/> Mandible	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Maxilla	<input type="checkbox"/>	<input type="checkbox"/>
SPECIAL TESTING		
<input type="checkbox"/> Cardiac Calcium Scoring		
<input type="checkbox"/> Lung Cancer Screening		
<input type="checkbox"/> Virtual Colonoscopy		
DEXA		
<input type="checkbox"/> Bone Densitometry		
<input type="checkbox"/> Vertebral Fracture Assessment		

GENERAL RADIOLOGY / DIGITAL XRAY		
<input type="checkbox"/> Skull	Rt. <input type="checkbox"/>	Lt. <input type="checkbox"/>
<input type="checkbox"/> Orbits	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Facial Bones		
<input type="checkbox"/> Nasal Bones		
<input type="checkbox"/> Paranasal Sinuses		
<input type="checkbox"/> Nasopharynx/STIM		
<input type="checkbox"/> Cervical Spine		
<input type="checkbox"/> Thoracic Spine		
<input type="checkbox"/> Lumbar		
<input type="checkbox"/> Spine/Pelvis		
<input type="checkbox"/> Pelvis		
<input type="checkbox"/> Sacrum/Coccyx		
<input type="checkbox"/> SI Joints		
<input type="checkbox"/> Scoliosis Series		
<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"/> Chest PA/LAT		
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sternum		
<input type="checkbox"/> Arm/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"/> Finger	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen-KUB		
<input type="checkbox"/> Abdomen-Flat/Upright		
<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"/> Heel/Calcaneous	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Toe	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>

SONOGRAPHY	
<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Retroperiton	
<input type="checkbox"/> Pelvis (Male, Female)	
<input type="checkbox"/> Transabdomen	
<input type="checkbox"/> Transvaginal	
<input type="checkbox"/> Transrectal	
<input type="checkbox"/> OB Sono	
<input type="checkbox"/> Biophysical Profile	
<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Breast	
<input type="checkbox"/> Scrotum/Testicle	
<input type="checkbox"/> Other _____	
COLOR DOPPLER	
<input type="checkbox"/> Echocardiogram	
<input type="checkbox"/> Carotid	
<input type="checkbox"/> Lower Extremity	
<input type="checkbox"/> Arterial <input type="checkbox"/> Bil <input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	
<input type="checkbox"/> Venous <input type="checkbox"/> Bil <input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	
<input type="checkbox"/> Transcranial	
<input type="checkbox"/> Other _____	
MAMMOGRAPHY	
<input type="checkbox"/> Screening <input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	
<input type="checkbox"/> Unilateral	

PREPARATION for DIAGNOSTIC PROCEDURES

The following simple instructions have been prepared for your convenience.

Your physician will check off the appropriate procedures.

Please follow these instructions carefully so that the procedures do not have to be repeated.

Please call us if you have any questions.

SONOGRAM (Ultrasound)

Abdominal Ultrasound (Gallbladder, Liver, Pancreas, Spleen, etc.)

For Morning Examination: Do not eat, smoke or drink anything after midnight or on the morning of your examination.

For Afternoon Examination: You may have a clear liquid breakfast but absolutely nothing to eat or drink for at least 6 hours prior to your exam.

Kidney (Renal) Ultrasound

Eat normally with this exam and drink 4 glasses of water just prior to the exam.

Obstetrical (Pregnancy) / Pelvic Ultrasound

Drink at least 32 oz. of liquid at least 1 hour before the exam. Do not go to the bathroom as you must have a full bladder for this exam otherwise your may be delayed. Patients who are in the third trimester of pregnancy need only drink 16 oz. of fluid.

Biophysical Profile (BPP)

Eat normally with this exam and drink 2 glasses of water just prior to the exam.

MRI (Magnetic Resonance Imaging)

There is no preparation required for this painless noninvasive procedure. Patients are welcome to bring along a cassette or CD to listen to, while undergoing the procedure or you can select one from our tape library.

Spiral CT Scanning (Cat Scan)

For any CT examination contrast, do not eat or drink anything for four hours before the test. No bowel prep is needed.

Directions to: Atlantic Radiology Imaging, P.C.

By Bus:

B82, B6 to Kings Highway and Bay Parkway (Kings Highway between Bay Parkway and Stillwell Avenue).

By Train:

N train to Kings Highway station.

D train to Bay Parkway station. Transfer to B82, B6.

F train to Kings Highway station. Transfer to B 82.

B82, B6 to Kings Highway and Bay Parkway (Kings Highway between Bay Parkway and Stillwell Avenue).

By Car:

From Manhattan: Take the Brooklyn Battery Tunnel, bear left onto the Prospect Expressway, Prospect Expressway becomes Ocean Parkway, continue on Ocean Parkway, turn SLIGHT RIGHT onto BAY PKWY, turn SLIGHT LEFT onto STILLWELL AVE, turn RIGHT onto KINGS HWY, end at 105 Kings Hwy.

From Staten Island: Cross Verrazano Bridge, take the Belt Parkway East, Exit 5, turn LEFT onto BAY PKWY, turn RIGHT onto KINGS HWY, end at 105 Kings Hwy.

