



PARAMUS MRI
ACR ACCREDITED



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30 W. Century Rd. Suite 100
Paramus, NJ 07652

***Entrance in rear of building**

*The area's leading provider in 1.5T Short Bore, Non Claustrophobic Fast Scanning Technology
(1.5T Siemens Magnetom Essenza)*

Patient _____

Referring Physician _____

Appointment Date _____ Appointment Time _____

Physician Phone # _____ Physician Fax # _____

CC Report to Doctor _____

Magnetic Resonance Imaging (MRI)

- Brain
- Pituitary
- Orbits
- Sinuses
- Internal Auditory Canal
- Temporal Mandibular Joint (Bilateral)
- Neck/Soft Tissue
- C-Spine
- T-Spine
- L-Spine
- Chest
- Pelvis
- Abdomen
- Other _____

Extremities

- | | R | L |
|--|--------------------------|--------------------------|
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <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"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Brachial Plexus | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tib/Fib (Calf) | <input type="checkbox"/> | <input type="checkbox"/> |

M R Angiography (MRA)

- MRA Neck
- MRA Head

With Contrast

Without Contrast

Precautionary Screening

- | | | |
|-------------------|------------------------------|-----------------------------|
| Patient Pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metallic Implants | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiac Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aneurysm Clip | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shrapnel | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cochlear Implant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Physician Signature _____

Clinical History & Reason for Study _____

**Complimentary transportation provided when needed*