

TEL: 212.879.4488

FAX: 212.737.5917

RX@ACCELERAD.CO

RCRDS@ACCELERAD.CO



**PRECISION
ACCELERAD**

WWW.ACCELERAD.CO

REF DR:

REF DR PHONE #:

REF DR ADDRESS:

REF DR SIGNATURE:

☐ STAT REPORT ☐ IMAGES ON CD ☐ ONLINE ACCESS ☐ FAX: _____

☐ NF ☐ WC ☐ LIEN ☐ SELF PAY ☐ PRIVATE INS ☐ MC DOI: _____

INSURANCE NAME: _____

CLAIM# / PRECER/REF #'S / ATTN: _____

APPT. DATE/TIME: _____

PATIENT NAME:

DATE ISSUED:

DOB:

PHONE #:

HISTORY/CLINICAL INFO:

MRI
☐ CLOSED 1.5T MRI ☐ 1.5T OVAL MRI ☐ 3T WIDE BORE MRI

I.V. CONTRAST: GFR _____

NEURO

	W/O	W/C	W & W/O
CERVICAL SPINE	<input type="checkbox"/> 72141	<input type="checkbox"/> 72142	<input type="checkbox"/> 72156
THORACIC SPINE	<input type="checkbox"/> 72146	<input type="checkbox"/> 72147	<input type="checkbox"/> 72157
LUMBAR SPINE	<input type="checkbox"/> 72148	<input type="checkbox"/> 72149	<input type="checkbox"/> 72158
BRAIN	<input type="checkbox"/> 70554	<input type="checkbox"/> 70552	<input type="checkbox"/> 70553
PITUITARY	<input type="checkbox"/> 70551	<input type="checkbox"/> 70552	<input type="checkbox"/> 70553
IACs	<input type="checkbox"/> 70551	<input type="checkbox"/> 70552	<input type="checkbox"/> 70553
ORBITS, FACE	<input type="checkbox"/> 70540	<input type="checkbox"/> 70542	<input type="checkbox"/> 70543
SINUSES	<input type="checkbox"/> 70540	<input type="checkbox"/> 70542	<input type="checkbox"/> 70543
TMJ	<input type="checkbox"/> 70336		
BRACHIAL PLEXUS	<input type="checkbox"/> 70540	<input type="checkbox"/> 70542	<input type="checkbox"/> 70543
MRA BRAIN	<input type="checkbox"/> 70544	<input type="checkbox"/> 70545	<input type="checkbox"/> 70546
MRA CAROTID	<input type="checkbox"/> 70547	<input type="checkbox"/> 70548	<input type="checkbox"/> 70549

BODY

	W/O	W/C	W & W/O
CHEST (CLAVICLE)	<input type="checkbox"/> 71550	<input type="checkbox"/> 71551	<input type="checkbox"/> 71552
PELVIS (ORTHO)	<input type="checkbox"/> 72195	<input type="checkbox"/> 72196	<input type="checkbox"/> 72197
ABDOMEN	<input type="checkbox"/> 74181	<input type="checkbox"/> 74182	<input type="checkbox"/> 74183

EXTREMITIES

	RT	LF	W/O	W/C	W & W/O
SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73221	<input type="checkbox"/> 73222	<input type="checkbox"/> 73223
HUMERUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73218	<input type="checkbox"/> 73219	<input type="checkbox"/> 73220
ELBOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73221	<input type="checkbox"/> 73222	<input type="checkbox"/> 73223
FOREARM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73218	<input type="checkbox"/> 73219	<input type="checkbox"/> 73220
WRIST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73221	<input type="checkbox"/> 73222	<input type="checkbox"/> 73223
HAND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73218	<input type="checkbox"/> 73219	<input type="checkbox"/> 73220
FINGER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73218	<input type="checkbox"/> 73219	<input type="checkbox"/> 73220

Specify _____

	RT	LF	W/O	W/C	W & W/O
HIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73721	<input type="checkbox"/> 73722	<input type="checkbox"/> 73723
THIGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73718	<input type="checkbox"/> 73719	<input type="checkbox"/> 73720
KNEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73721	<input type="checkbox"/> 73722	<input type="checkbox"/> 73723
LOWER LEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73718	<input type="checkbox"/> 73719	<input type="checkbox"/> 73720
ANKLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73721	<input type="checkbox"/> 73722	<input type="checkbox"/> 73723
FOOT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73718	<input type="checkbox"/> 73719	<input type="checkbox"/> 73720
TOE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 73718	<input type="checkbox"/> 73719	<input type="checkbox"/> 73720

Specify _____

OTHER: _____

CT

I.V. CONTRAST: CREAT _____

	W/O	W/C
CERVICAL SPINE w/3D	<input type="checkbox"/> 72125+76376	<input type="checkbox"/> 72126+76376
THORACIC SPINE w/3D	<input type="checkbox"/> 72128+76376	<input type="checkbox"/> 72129+76376
LUMBAR SPINE w/3D	<input type="checkbox"/> 72131+76376	<input type="checkbox"/> 72132+76376
NECK SOFT TISSUE w/3D	<input type="checkbox"/> 70490+76376	<input type="checkbox"/> 70492+76376
BRAIN w/3D	<input type="checkbox"/> 70450+76376	<input type="checkbox"/> 70460+76376
ORBITS w/3D	<input type="checkbox"/> 70480+76376	<input type="checkbox"/> 70481+76376
TEMPORAL BONES/IAC w/3D	<input type="checkbox"/> 70480+76376	<input type="checkbox"/> 70481+76376
SINUSES w/3D	<input type="checkbox"/> 70486+76376	<input type="checkbox"/> 70487+76376
CHEST w/3D	<input type="checkbox"/> 71250+76376	<input type="checkbox"/> 71260+76376
PELVIC BONES w/3D	<input type="checkbox"/> 72192+76376	<input type="checkbox"/> 72193+76376
ABDOMEN w/3D	<input type="checkbox"/> 74150+76376	<input type="checkbox"/> 74160+76376

JOINT or EXTREMITY

Specify _____

OTHER: _____

MRI ARTHROGRAM

US GUIDED: Please indicate body part:

ULTRASOUND

Please indicate body part:

X-RAYS

<input type="checkbox"/> CHEST	<input type="checkbox"/> PA/LAT	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> CLAVICLE	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> PA			<input type="checkbox"/> SCAPULA	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> ABDOMEN			<input type="checkbox"/> SHOULDER	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> FLAT	<input type="checkbox"/> ERECT	<input type="checkbox"/> DECUB	<input type="checkbox"/> HUMERUS	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> PELVIC AP			<input type="checkbox"/> ELBOW	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> HEAD			<input type="checkbox"/> FOREARM	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> SKULL	<input type="checkbox"/> SINUS	<input type="checkbox"/> ORBITS	<input type="checkbox"/> WRIST	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> FACIAL BONES			<input type="checkbox"/> HAND	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> NASAL BONES	<input type="checkbox"/> MANDIBLE		<input type="checkbox"/> FINGER	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> CERVICAL SPINE			<input type="checkbox"/> HIP	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> 2 VIEWS	<input type="checkbox"/> 4 VIEWS	<input type="checkbox"/> STANDING	<input type="checkbox"/> FEMUR	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> FLEX/EXT			<input type="checkbox"/> KNEE	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> THORACIC			<input type="checkbox"/> TIB-FIB	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> STANDING			<input type="checkbox"/> ANKLE	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> LUMBAR SPINE			<input type="checkbox"/> FOOT	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B
<input type="checkbox"/> 2 VIEWS	<input type="checkbox"/> 4 VIEWS	<input type="checkbox"/> STANDING	<input type="checkbox"/> TOE			
<input type="checkbox"/> FLEX/EXT			<input type="checkbox"/> WEIGHTBEARING	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> SCOLIOSIS SERIES			<input type="checkbox"/> OTHER: _____			
<input type="checkbox"/> AC JOINTS						
<input type="checkbox"/> RIBS	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B			

NOTES & RULE OUTS:

*If you would like to view your patient's images online please visit: **Precision.brit.com** Please call or email for login info.

Please fax all Referrals to 212-737-5917 at time of scheduling the appointment. We require a copy of referral, prior to patient arrival.

Email Referrals to: RX@ACCELERAD.CO

CALL US AFTER HOURS @ 212-879-4488 - Press 6

LOCATIONS & DIRECTIONS

☐ UPPER EAST SIDE - 3T WIDE BORE MRI

170 EAST 77TH STREET
NEW YORK, NY 10075

The facility is located at 170 East 77th Street, between Lexington and 3rd Avenue in Manhattan.

The entrance is to the left of the residential building. Proceed through the glass doors then straight down the hallway to the large double doors. We are located inside Solis Health and Simon Med.

6 Train to 77th Street. Walk half a block east.

M79 Bus to 3rd Ave. or Lexington Ave. Walk 2 blocks to 77th Street. We are btw Lexington & 3rd Ave

☐ BRONX THROGGSNECK - 1.5T MRI

3620 EAST TREMONT AVENUE
BRONX, NY 10465

The facility is located on East Tremont Avenue between Phillip Ave & Lafayette Ave.

We are conveniently located blocks from the Cross Bronx Expy, the Throggs Neck Expy and i95.

The Bx40 and Bx42 buses stop right outside our front door which can be accessed from many subway lines.

☐ NOTES:

☐ MADISON AVENUE - 1.5T OVAL MRI, XRAY

1820 MADISON AVENUE
NEW YORK, NY 10035

The facility is located on Madison Avenue, Between 118th & 119th streets in Manhattan.

We are conveniently located 3 blocks from the 6 Train and 3 blocks from the 2 & 3 trains

2 blocks from the M116 & M102 buses and the M1 Bus stops right in front of our facility. We have a CitiBike station around the corner should you choose to ride.

Metered parking surrounds the area, along with multiple covered garages.

Please call our office if you need assistance locating the entrance.

☐ MAIN OFFICE - BILLING, ADMIN, RECORDS

222 EAST 68TH STREET
NEW YORK, NY 10065

The Main Office is located on the 3rd floor on East 68th Street.

6 Train to 68th Street. Walk East 1 block. We are located on the south side of the street.

Please mail all correspondence to our Main Office.

Please call ahead to schedule a medical records pick up.

EXAM PREPARATIONS

- Continue taking any prescription medications, which may be taken with a few sips of water prior to the exam.
- Please be sure you have your referral or prescription from your doctor, as well as a Photo ID.
- Wear comfortable clothing and DO NOT wear earrings, hairpins or jewelry.

MRI/MRA

This exam may not be performed if you have a cardiac pacemaker, cerebral aneurysm clips or a metallic hearing implant.

If you are a sheet metal worker, have been shot, or have ever had metal fragments, an x-ray must be taken prior to your MRI/MRA exam.

If you are receiving IV CONTRAST for your exam, have nothing to eat 1 hour prior to your exam. You may drink clear liquids (example: water, ginger ale, apple juice).

CT SCAN

CT Scans are done at our Manhattan location.

If you have a history of asthma, an allergy to iodine, or are currently taking medication for diabetes, please notify our staff.

If you are receiving IV CONTRAST or ORAL CONTRAST for your exam, have nothing to eat 1 hour prior to your exam.

You may drink clear liquids (example: water, ginger ale, apple juice).

If you have questions about these instructions or directions, please call us before your appointment.
Please give 24 hour notice to cancel or reschedule your appointment.