



JERSEY SHORE RADIOLOGY

JERSEY SHORE IMAGING

NEPTUNE

Jersey Shore Imaging
Medical Arts Building
2100 Corlies Ave.
Neptune, NJ 07753
Phone: (732) 988-1234
FAX: (732) 502-0368

FREEHOLD

Jersey Shore Radiology
Doctors Park
900 West Main St.
Freehold, NJ 07728
Phone: 732-462-1900
FAX: (732) 462-1848

BRICK/POINT PLEASANT

Jersey Shore Radiology
River Medical Park
3822 River Road
Point Pleasant, NJ 08742
Phone: (732) 892-1200
FAX: (732) 892-1202

OAKHURST

Central Jersey Radiology
2128 Kings Highway
and Route 35
Oakhurst, NJ 07755
Phone: (732) 892-1200
FAX: (732) 892-1202

REFERRAL FOR RADIOLOGICAL STUDY

PATIENT NAME		APPOINTMENT DATE/TIME	Prior Studies? YES <input type="checkbox"/> / NO <input type="checkbox"/>
CLINICAL INFORMATION			If YES, Where _____ When? _____
			<input type="checkbox"/> Call in Results? # _____
			<input type="checkbox"/> Fax Report? # _____
			REFERRING DOCTOR SIGNATURE
			X

X-RAY

- | | | |
|--|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Abdomen (KUB) | <input type="checkbox"/> Chest | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Skull |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Ribs | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> Extremities _____ | | |
| <input type="checkbox"/> Other _____ | | |

FLUOROSCOPY/IVP

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Esophagram | <input type="checkbox"/> UGI w/ Small Bowel |
| <input type="checkbox"/> Small Bowel | <input type="checkbox"/> Barium Enema (With Air? YES <input type="checkbox"/> / NO <input type="checkbox"/>) |
| <input type="checkbox"/> IVP | <input type="checkbox"/> Upper GI |
| <input type="checkbox"/> Other _____ | |

MAMMOGRAPHY

- | | |
|---|---|
| <input type="checkbox"/> Screening-Asymptomatic | <input type="checkbox"/> Diagnostic-Symptomatic |
| <input type="checkbox"/> Breast Ultrasound (if indicated) | <input type="checkbox"/> Unilateral (L / R) |

SPECIAL PROCEDURES

- | | |
|--|---|
| <input type="checkbox"/> Breast Localization | <input type="checkbox"/> FNA (Fine Needle Aspiration) |
| <input type="checkbox"/> PICC Line | <input type="checkbox"/> Breast Biopsy |
| <input type="checkbox"/> Breast Cyst Aspiration | |
| <input type="checkbox"/> Hysterosalpingogram | |
| Specify _____ | |
| <input type="checkbox"/> Biopsies & Other Minimally Invasive Procedure | |
| Specify _____ | |

ULTRASOUND

- | | | |
|---|--|--|
| <input type="checkbox"/> Breast | <input type="checkbox"/> Obstetrical | <input type="checkbox"/> Pelvic/Transvaginal |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvic | <input type="checkbox"/> Renal |
| <input type="checkbox"/> Transvaginal | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Renal Artery Doppler |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Scrotum | <input type="checkbox"/> Hysterosonography |
| <input type="checkbox"/> Abdominal Aorta | <input type="checkbox"/> Carotid Duplex | <input type="checkbox"/> Arterial Doppler w/ ABI's |
| <input type="checkbox"/> Pyloric Stenosis | <input type="checkbox"/> Venous Doppler | <input type="checkbox"/> Neonatal Hip |
| <input type="checkbox"/> Neonatal Head | <input type="checkbox"/> Nuchal Translucency | |
| <input type="checkbox"/> Other _____ | | |

MRI

High Field MRI Open MRI

- | | | |
|---|---|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> TMJ's | <input type="checkbox"/> MRA Carotids |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Breast | <input type="checkbox"/> MRA Circle of Willis |
| <input type="checkbox"/> IAC's | <input type="checkbox"/> Pelvis | <input type="checkbox"/> MRA Lower Extremities |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Soft Tissue Neck |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> MRA Renal Arteries | <input type="checkbox"/> Brachial Plexus |
| <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Sacrum/Coccyx |

Attn:

- | | | |
|--------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Liver | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Other _____ | | |

Extremities:

- | | | |
|---|--|--|
| <input type="checkbox"/> Shoulder (L / R) | <input type="checkbox"/> Knee (L / R) | <input type="checkbox"/> Hip (L / R) |
| <input type="checkbox"/> Elbow (L / R) | <input type="checkbox"/> Ankle (L / R) | <input type="checkbox"/> Foot (L / R) |
| <input type="checkbox"/> Wrist (L / R) | <input type="checkbox"/> Femur (L / R) | <input type="checkbox"/> Tip/Fib (L / R) |
| <input type="checkbox"/> Other _____ | | |

Contrast Options:

- | | | |
|--|---|--|
| <input type="checkbox"/> With/Without Contrast | <input type="checkbox"/> Without Contrast | <input type="checkbox"/> Per Radiologist |
|--|---|--|

CT

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest | <input type="checkbox"/> Enterography | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Head | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Abdomen/Pelvis |
| <input type="checkbox"/> C Spine | <input type="checkbox"/> T Spine | <input type="checkbox"/> L Spine |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> IAC's/Posterior Fossa | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> Mastoids | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Cardiac Scoring |
| <input type="checkbox"/> CT Urogram | <input type="checkbox"/> Renal Stone Protocol | <input type="checkbox"/> Virtual Colonoscopy |
| <input type="checkbox"/> Extremities _____ | | |
| <input type="checkbox"/> Other _____ | | |

Contrast Options:

- | | | |
|--|---|--|
| <input type="checkbox"/> With/Without Contrast | <input type="checkbox"/> Without Contrast | <input type="checkbox"/> Per Radiologist |
|--|---|--|

DEXA

- | |
|--|
| <input type="checkbox"/> Bone Density Study |
| <input type="checkbox"/> Vertebral Fracture Assessment (Available in Freehold Office Only) |