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PATIENT NAME: _____ TEL #: _____

CLINICAL INFORMATION: _____

PHYSICIAN NAME: _____

PHYSICIAN PHONE #: _____

DATE: _____

Form containing various medical imaging options: CT 64 MULTIDETECTOR, PET/CT, FILM PREFERENCE, CT ANGIOGRAPHY, CT SCREENING STUDIES, N.M. SCINTIGRAPHY, ULTRASOUND, X-RAY, MR ANGIOGRAPHY, MAMMO/BREAST IMAGING, DENSITOMETRY.

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

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