



BREWSTER: 3839 Danbury Road, Brewster, New York 10509 (845) 278-6200
DANBURY: 73 Sand Pit Road, Suite 209, Danbury, CT 06810 (203) 798-0303
BROOKFIELD: 31 Old Route 7, Brookfield, CT 06804 (203) 775-4300

Toll Free (888) 778-6200 NERad.com Fax (845) 278-4033

PATIENT NAME: _____ DATE OF BIRTH _____

HISTORY: _____

REFERRING PHYSICIAN _____ C.C. _____

WOMEN'S IMAGING	CT SCANNING (MULTIDETECTOR)	HIGH FIELD MRI, OPEN MRI, EXTREMITY MRI
<input type="checkbox"/> Digital Mammogram Bilateral or Uni (Right or Left) <input type="checkbox"/> Ultrasound Breast Bilateral or Uni (Right or Left) <input type="checkbox"/> MRI Breast Bilateral or Uni (Right or Left) <input type="checkbox"/> MRI Breast Implant Bilateral or Uni (Right or Left) <input type="checkbox"/> DEXA Bone Densitometry with LVA <input type="checkbox"/> Obstetrical Ultrasound <input type="checkbox"/> 1st Trimester <input type="checkbox"/> Nuchal Translucency Evaluation <input type="checkbox"/> 2nd Trimester (Anatomy) <input type="checkbox"/> 3rd Trimester <input type="checkbox"/> Pelvic Ultrasound (with Doppler) <input type="checkbox"/> Transvaginal Ultrasound (with Doppler) <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> Hysterosalpingogram	<input type="checkbox"/> w/o Contrast <input type="checkbox"/> w/Contrast <input type="checkbox"/> w/o & w/ Contrast <input type="checkbox"/> Brain <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Full coronal and axial <input type="checkbox"/> Limited axials only <input type="checkbox"/> Orbits <input type="checkbox"/> Mastoid/Temporal Bone <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Parotid Gland <input type="checkbox"/> Larynx <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Chest <input type="checkbox"/> Standard <input type="checkbox"/> High Resolution <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Abdomen only <input type="checkbox"/> Pelvis only <input type="checkbox"/> Extremity / Joint <input type="checkbox"/> Angiography <input type="checkbox"/> Head <input type="checkbox"/> Carotid <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta with lower extremities <input type="checkbox"/> Cardiac <input type="checkbox"/> Coronary <input type="checkbox"/> CT Colonography <input type="checkbox"/> Coronary Calcium Scoring <input type="checkbox"/> CT Urogram	Head & Neck <input type="checkbox"/> Brain <input type="checkbox"/> MR Perfusion <input type="checkbox"/> MR Spectroscopy <input type="checkbox"/> MR Diffusion Tensor Imaging <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> IACs <input type="checkbox"/> TMJs <input type="checkbox"/> Facial / Sinuses <input type="checkbox"/> Neck <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> MRA Circle of Willis <input type="checkbox"/> MRA Vertebrobasilar <input type="checkbox"/> MRA Carotids <input type="checkbox"/> MR Venography Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Lumbosacral (Post-Op) Spine <input type="checkbox"/> Sacrum Musculoskeletal <input type="checkbox"/> Knee R or L <input type="checkbox"/> Shoulder R or L <input type="checkbox"/> Elbow R or L <input type="checkbox"/> Wrist R or L <input type="checkbox"/> Ankle R or L <input type="checkbox"/> Hip R or L <input type="checkbox"/> Other R or L _____ Body <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen (general) <input type="checkbox"/> Pelvis <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> MR Cholangiogram/MRCP <input type="checkbox"/> MRA Chest <input type="checkbox"/> MRA Abdomen <input type="checkbox"/> MRA Pelvis <input type="checkbox"/> MRA Lower Extremities <input type="checkbox"/> w/o Contrast <input type="checkbox"/> w/Contrast <input type="checkbox"/> w/o & w/ Contrast
FLUOROSCOPY & SPECIAL PROCEDURES	ULTRASOUND	DIGITAL X-RAY
<input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI Series <input type="checkbox"/> Small Bowel Follow Through <input type="checkbox"/> Barium Enema <input type="checkbox"/> IVP <input type="checkbox"/> VCUG <input type="checkbox"/> Arthrography Side _____ Location _____ <input type="checkbox"/> Myelography Spine Location _____	<input type="checkbox"/> Abdomen with Doppler <input type="checkbox"/> Renal with Doppler <input type="checkbox"/> Bladder with Doppler <input type="checkbox"/> Aorta with Doppler <input type="checkbox"/> Pelvis with Doppler <input type="checkbox"/> Thyroid <input type="checkbox"/> Testicular with Doppler <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Lower Extremity Doppler: <input type="checkbox"/> Arterial <input type="checkbox"/> Venous <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Infant: <input type="checkbox"/> Head <input type="checkbox"/> Hip <input type="checkbox"/> Pyloric Stenosis <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Other _____ <input type="checkbox"/> No Doppler	<input type="checkbox"/> X-ray Side _____ Location _____ Special Instructions: _____
NUCLEAR MEDICINE	BIOPSY	Please provide patient with CD
<input type="checkbox"/> Bone Scan (Whole Body) <input type="checkbox"/> Bone Scan (3 Phase): _____ <input type="checkbox"/> Bone SPECT <input type="checkbox"/> Liver-Spleen Scan <input type="checkbox"/> Renal Scan <input type="checkbox"/> Gallium Scan <input type="checkbox"/> MUGA Rest <input type="checkbox"/> HIDA <input type="checkbox"/> CCK-HIDA <input type="checkbox"/> Cystogram <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> I131 Whole Body Imaging <input type="checkbox"/> Parathyroid <input type="checkbox"/> Brain SPECT <input type="checkbox"/> Other _____	<input type="checkbox"/> CT Guided _____ Location _____ <input type="checkbox"/> MR Guided _____ <input type="checkbox"/> US Guided <input type="checkbox"/> Stereotactic	Other Instructions: _____
PET/CT		
<input type="checkbox"/> Whole Body <input type="checkbox"/> Brain		

NORTHEAST RADIOLOGY PATIENT PREPS

- MRI EXAMS: You will be called by our Radiology aide and interviewed prior to your scheduled examination.
- CT SCANS WITH CONTRAST: Nothing to eat or drink 4 hours before examination.
- ULTRASOUND:
 - ABDOMEN: Nothing to eat or drink after midnight.
 - ABDOMEN WITH PELVIS, BLADDER: Nothing to eat or drink after midnight. Day of exam 24-32 ounces of water 1 1/2 hours before exam, and finish water within a half hour. Arrive with full bladder.
 - OB: Day of exam drink 24 ounces of water, 1 1/2 hours before exam and finish water within a half hour. Arrive with full bladder.
- BIOPSIES: Follow your Physician's instructions and you will be called by our Radiology Nurse.
- NUCLEAR MEDICINE:
 - MUGA SCAN: Nothing by mouth 4 hours before exam. You will be contacted by a radiology nurse prior to your scheduled cardiac exam.
 - HIDA SCAN: Nothing by mouth 4 hours before exam.
- UPPER GI, SMALL BOWEL: Nothing by mouth after midnight.
- BARIUM ENEMA: (BE) and INTRAVENOUS PYELOGRAM: (IVP)
 - 1. 24 hours prior to study: Clear liquid diet. Example: plain jello, Coca-Cola, ginger ale, clear broth.
 - 2. 60 ml(2 oz) magnesium citrate by mouth at 5:00 P.M. the night prior to the exam.
 - 3. Bisacodyl (Dulcolax) 4 tablets by mouth at 10:00 P.M. the night prior to the exam.
 - 4. For Barium Enema Only: Bisacodyl (Dulcolax) suppository upon waking the morning of the exam.
 - 5. Do not eat or drink anything after midnight.
- MAMMOGRAPHY: No powders or deodorants.
- MYELOGRAPHY: Nothing by mouth 2 hours before examination. Do not take phenothiazines, MAO inhibitors or tricyclic antidepressants for 48 hours prior to exam. You will receive a call from our Radiology Nurse prior to your scheduled exam.
- PET/CT: Our personnel will contact you prior to your examination with detailed instructions.

Please feel free to call us anytime if you have any questions or concerns. Thank you.

DANBURY:

Take Exit 7 off I-84 towards New Milford/Brookfield.

Merge onto Route 7 North. Take the first exit on Route 7 (exit 11) towards Federal Road.

Turn right at the traffic light at the end of the ramp onto White Turkey Road for approximately 1 mile. Turn left onto Federal Road and stay in the right lane. Turn right onto Starr Road at the second traffic light. Proceed on Starr Road to the first traffic light.

Bear right onto Sand Pit Road. The Medical Center of Western Connecticut is approximately one-half mile on the left.

Turn left into the complex. Building number 73 is on your left.

Park in the second parking lot, just past the building.

BREWSTER:

From Connecticut: (5 minutes west of the mall)

Take I-84 west to CT Exit #1 (Saw Mill Rd.) Turn right at the end of the ramp and left onto Route 6 west.

Continue on Route 6 west for one mile to the intersection of Dingle Ridge Road. Our facility is on the left.

From New York:

A) Take I-684 North to Exit #10 (Brewster). Turn left at the end of the ramp onto Route 6 east/Route 202 east.

Continue for 2 miles to the intersection of Dingle Ridge Road. Our facility is on the right.

Or

B) Take I-84 East to Exit #20N (Brewster-Pawling) which leads to the last section of I-684 North. Then follow directions from (A) above.

BROOKFIELD:

From I-84

Take Exit 7 off I-84 towards New Milford/Brookfield. Merge on to Route 7 North and follow to Exit 12.

Make a right at the light on to Federal Road.

Take your next left (approximately 150 yards) onto Laurel Hill Road and a right into the medical building parking lot. The entrance is on the lower level.

From Route 7 South

Take Route 7 South. Travel approximately 1/2 mile past Four Corners in Brookfield, and turn right onto Laurel Hill Road and a right into the medical building parking lot. The entrance is on the lower level.