



# MILLBURN MEDICAL IMAGING, P.A.

## AT MAPLEWOOD

2130 MILLBURN AVE.  
MAPLEWOOD, NJ, 07040

(973) 912-0404 • Fax (973) 912-0444

**FULL SERVICE FACILITY**

## AT LINDEN

210 WEST ST. GEORGES AVE.  
LINDEN, NJ, 07036

(908) 587-0035 • Fax (908) 587-0037

**HIGH FIELD MRI CENTER**

PATIENT'S NAME \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

DATE \_\_\_\_\_ AT \_\_\_\_\_ A.M.  
P.M.

DIAGNOSIS \_\_\_\_\_

**PATIENT INSTRUCTIONS ON BACK OF SHEET**

REFERRING PHYSICIAN'S SIGNATURE \_\_\_\_\_

**CT SCAN**

BRAIN  
 INTERNAL AUDITORY CANALS  
 SINUSES  
 C-SPINE  
 T-SPINE  
 L-SPINE  
 CHEST  
 CT ANGIO  
 ABDOMEN  
 PELVIS  
 ORBITS  
 DENTAL CT  
 OTHER \_\_\_\_\_  
 3D FOR CT ABOVE  
 IV CONTRAST Yes No

**X-RAY**

INTRAVENOUS PYELOGRAM (IVP)  
 SKULL  CHEST  
 SINUSES  L-SPINE  
 NASAL/FACIAL  ABDOMEN  
 C-SPINE  PELVIS  
 T-SPINE  
 OTHER \_\_\_\_\_

**EXTREMITIES:**

	LEFT	RIGHT
<input type="checkbox"/> SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HUMERUS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> RADIUS/ULNA	<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"/> FEMUR	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> KNEE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TIBIA/FIBULA	<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"/> RIBS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>

**MRI HEAD**

BRAIN  
 IAC  
 ORBITS  
 PITUITARY  
 SINUS  
 TMJ  
 OTHER \_\_\_\_\_

**MRI SPINE**

C-SPINE  
 T-SPINE  
 L-SPINE  
 OTHER \_\_\_\_\_

**ULTRASOUND**

**OBSTETRICS/GYNECOLOGY:**

PELVIC  
 (PERFORM TRANSVAGINAL WHEN NEEDED)  
 TRANSVAGINAL  
 OB  
 BREAST  L  R  
 THYROID  KIDNEYS  
 AORTA  TESTICULAR  
 ABDOMEN  
 PELVIS — MALE  
 RETROPERITONEUM  
 OTHER \_\_\_\_\_  
 THYROID BIOPSY  
 US GUIDED BIOPSY  L  R

**MRI EXTREMITIES**

	LEFT	RIGHT
<input type="checkbox"/> FOOT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ANKLE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> KNEE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HIP	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FINGER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HAND	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> WRIST	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ELBOW	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SHOULDER ARTHROGRAM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HIP ARTHROGRAM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> KNEE ARTHROGRAM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ELBOW ARTHROGRAM	<input type="checkbox"/>	<input type="checkbox"/>

**MRI ABDOMEN**

ABD  
 LIVER \_\_\_\_\_  
 KIDNEYS \_\_\_\_\_  
 PANCREAS \_\_\_\_\_  
 PELVIS  
 MRCP

**MRI / MRV**

CAROTID  
 INTRA CRANIAL  
 RENAL  
 AORTA-FEMORAL  
 EXTREMITY  
 UPPER  
 LOWER  
 OTHER \_\_\_\_\_

**CONTRAST**

WITHOUT  
 WITHOUT AND WITH

**COLOR DOPPLER STUDIES**

DUPLEX CAROTID  W/3D  
 DUPLEX PERIPHERAL ARTERY  
 UPPER  L  R  BOTH  
 LOWER  L  R  BOTH  
 DUPLEX VENOUS DOPPLER  
 UPPER  
 LOWER  
 W/3D  
 ABDOMEN (SPECIFY) \_\_\_\_\_  
 OTHER \_\_\_\_\_

**PHYSIOLOGIC NON-INVASIVE VASCULAR STUDIES**

PULSE RECORDING AND SEGMENTED PRESSURES  
 OTHER \_\_\_\_\_  
 UPPER  L  R  
 LOWER  L  R

**BONE DENSITOMETRY**

DEXA SCAN

SPECIAL INSTRUCTIONS:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**BREAST IMAGING**

**MAMMOGRAPHY**

SCREENING  
 DIAGNOSTIC  
 UNILATERAL  L  R  
 PERFORM BREAST US WHEN INDICATED

**ULTRASOUND**

BREAST  L  R  
 US GUIDED BIOPSY  L  R  
 US GUIDED FINE NEEDLE ASPIRATION  L  R

**BREAST MRI**

MRI BREAST  
 UNILATERAL  BILATERAL  
 BREAST BIOPSY  
 BREAST PATHOLOGY w/o & w/  
 BREAST IMPLANTS  
 MRI GUIDED BIOPSY  
 L  R  
 MRI NEEDLE LOCALIZATION  
 L  R  
 OTHER \_\_\_\_\_  
 CHECK HERE IF PATIENT IS CLAUSTROPHOBIC

**ALAN HEIDEMAN, M.D.**

**KENNETH BLATT, M.D.**

**PREPARING FOR YOUR EXAMINATION**

• **CT SCANNING OF ABDOMEN/PELVIS**

DAY BEFORE EXAM, COME TO THE OFFICE TO PICK UP BARIUM DRINK (FURTHER INSTRUCTIONS WILL BE PROVIDED AT THE FACILITY). PLEASE INFORM THE STAFF OF ANY ALLERGIES OR HISTORY OF DIABETES.

• **PELVIC/OB SONOGRAM (ULTRASOUND)**

FINISH DRINKING SIX 8 OZ. GLASSES OF WATER ONE HOUR BEFORE YOUR EXAM TIME. DO NOT URINATE BEFORE YOUR EXAM. YOUR BLADDER NEEDS TO BE FULL FOR OPTIMUM RESULTS.

• **ABDOMINAL SONOGRAM**

NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE YOUR EXAM. ABDOMINAL SONOGRAMS ARE DONE IN THE MORNING BEFORE NOON.

• **MAMMOGRAPHY**

FOR YOUR COMFORT, WE RECOMMEND THAT YOU SCHEDULE YOUR EXAM AFTER THE FIRST DAY OF YOUR MENSTRUAL CYCLE. PLEASE DO NOT USE TALCOM POWDER, PERFUME, OR DEODORANT IN THE BREAST AREA ON THE DAY OF YOUR EXAM.

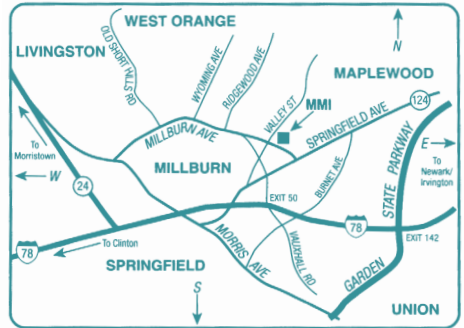
• **IF YOU HAVE IMPLANTS, PLEASE INFORM OUR STAFF AT THE TIME OF MAKING YOUR APPOINTMENT.**

**DIRECTIONS TO MAPLEWOOD:**

**GARDEN STATE PARKWAY TO ROUTE 78 WEST.** GET OFF AT **EXIT 50B** AND GET IN LEFT LANE ON **VAUXHALL ROAD**. AT 3RD TRAFFIC LIGHT MAKE A **RIGHT** ONTO **VALLEY STREET**. GO THRU NEXT LIGHT. **MILLBURN MEDICAL IMAGING IS FIRST PARKING LOT ON THE RIGHT.**

**PUBLIC TRANSPORTATION** — 25 MAPLEWOOD LOOP. **70** BUS FOR LIVINGSTON MALL. STOP AT CORNER OF **VALLEY STREET AND MILLBURN AVENUE.**

**MILLBURN MEDICAL IMAGING**



**DIRECTIONS TO LINDEN:**

**GARDEN STATE PARKWAY SOUTH** — TAKE **EXIT 136** (LINDEN/ROSELLE/WINFIELD). AT THE END OF THE RAMP — TURN SLIGHT **RIGHT** ONTO JUG HANDLE. AT THE LIGHT, TURN **LEFT** ONTO **CENTENNIAL AVENUE**. AT THE SECOND TRAFFIC LIGHT, TURN **LEFT** ONTO **RARITAN ROAD**. AT THE LIGHT, TURN **RIGHT** ONTO **DEWITT STREET**. PROCEED STRAIGHT UNTIL YOU COME TO A TRAFFIC LIGHT, WHICH WILL BE **ST. GEORGES AVENUE**. AT THIS LIGHT, TURN **LEFT** BUILDING WILL BE ON YOUR **LEFT** SIDE. PARKING IN THE REAR.

**GARDEN STATE PARKWAY NORTH** — TAKE **EXIT 136** (LINDEN/ROSELLE/WINFIELD). AT THE END OF EXIT RAMP, BEAR **RIGHT** (TRAFFIC LIGHT). AT THE SECOND TRAFFIC LIGHT, TURN **LEFT** ONTO **RARITAN ROAD**. AT THE LIGHT, TURN **RIGHT** ONTO **DEWITT STREET**. PROCEED STRAIGHT UNTIL YOU COME TO A TRAFFIC LIGHT, WHICH WILL BE **ST. GEORGES AVENUE**. AT THIS LIGHT, TURN **LEFT** BUILDING WILL BE ON YOUR **LEFT** SIDE. PARKING IN THE REAR.

**TURNPIKE NORTH OR SOUTH** — TAKE **EXIT 13**. FOLLOW SIGNS FOR **ROUTE 1 & 9 SOUTH**. TURN **RIGHT** ONTO **SOUTH WOOD AVENUE**. PROCEED STRAIGHT THROUGH APPROXIMATELY 10 TRAFFIC LIGHTS. THE 11TH TRAFFIC LIGHT IS **ST. GEORGES AVENUE**. TURN **LEFT** BUILDING WILL BE ON YOUR **LEFT** AFTER THE 2ND TRAFFIC LIGHT NEXT TO DINER. PARKING IN THE REAR.

**PUBLIC TRANSPORTATION** — FROM **ELIZABETH** TAKE NJ TRANSIT BUS ROUTE **#57** TO **WOOD AVENUE AND ST. GEORGES AVENUE** IN LINDEN. FROM **NEWARK** TAKE NJ TRANSIT BUS ROUTE **#62** TO SAME LOCATION. PROCEED ON ST. GEORGES AVENUE TOWARDS LINDEN H.S., FACILITY IS LOCATED NEXT TO LINDEN DINER ON THE RIGHT HAND OF THE STREET.

**MILLBURN MEDICAL IMAGING MRI CENTER AT LINDEN**

