Patient Information

Last Name: ______________________

First Name: ______________________

Date of Birth: ______________________

NEURO CONSULT SHEET

Physician Information

Referring Physician: ______________________

Address: ______________________

Office Number: ______________________

Primary Care Physician: ______________________

Address: ______________________

Office Number: ______________________

Other Physician(s) following your care: ______________________ Specialty: ______________

Address: ______________________

Office Number: ______________________

Other Physician(s) following your care: ______________________ Specialty: ______________

Address: ______________________

Office Number: ______________________

Other Physician(s) following your care: ______________________ Specialty: ______________

Address: ______________________

Office Number: ______________________

Other Physician(s) following your care: ______________________ Specialty: ______________

Address: ______________________

Office Number: ______________________

Pharmacy Information

Pharmacy Name: ______________________

Address: ______________________

Phone Number: ______________________

Approved. Effective 05.07.2019

UNIVERSITY RADIOLOGY

Patient Information

Last Name: ______________________

First Name: ______________________

Date of Birth: ______________________

Reason for today's visit: ______________________

Systems Review: Have you experienced any of the following (please select all that apply)

Weight Loss ☐ Y ☐ N If yes, how much? ______________________

Weight Gain ☐ Y ☐ N If yes, how much? ______________________

Back Pain ☐ Y ☐ N If yes, location? ☐ Upper ☐ Mid ☐ Lower

Weakness	☐ Y ☐ N	Fatigue	☐ Y ☐ N	Skin Color Changes	☐ Y ☐ N
Chills	☐ Y ☐ N	Night Sweats	☐ Y ☐ N	Problems with Hair and/or Nails	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	Fever	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N
Seizures	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N	Blood Clots / Emboli	☐ Y ☐ N
Stroke	☐ Y ☐ N	Paralysis	☐ Y ☐ N	Tender / Swollen Lymph Nodes	☐ Y ☐ N
Headaches	☐ Y ☐ N	Nose Bleeds	☐ Y ☐ N	Difficulty Breathing with Activity	☐ Y ☐ N
UTI	☐ Y ☐ N	Chest Pain	☐ Y ☐ N	Increased Urination	☐ Y ☐ N
Malaise	☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Frequent Urination	☐ Y ☐ N
Lesions	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Painful Urination	☐ Y ☐ N
Tremors	☐ Y ☐ N	Palpitations	☐ Y ☐ N	Coronary Artery Disease	☐ Y ☐ N
Syncope	☐ Y ☐ N	Hypertension	☐ Y ☐ N	Excessive Skin Dryness	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Kidney Stones	☐ Y ☐ N	Swelling in Arms / Legs	☐ Y ☐ N
Dizziness	☐ Y ☐ N	Varicose Veins	☐ Y ☐ N	Loss of Feeling in Arms / Legs	☐ Y ☐ N

Medical History: Do you have any of the following conditions (please select all that apply)

Asthma	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N
Hypertension	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Stomach Ulcers	☐ Y ☐ N
Seizures	☐ Y ☐ N	Head Injury	☐ Y ☐ N	Myasthenia Gravis	☐ Y ☐ N
Glaucoma	☐ Y ☐ N	Multiple Myeloma	☐ Y ☐ N	Have you ever been transfused	☐ Y ☐ N
Liver Disease	☐ Y ☐ N	Anemia	☐ Y ☐ N	Bleeding Disorders	☐ Y ☐ N
Lung Disease	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N	Pheochromocytosis	☐ Y ☐ N
Osteoarthritis	☐ Y ☐ N	Heart Disease	☐ Y ☐ N	Intestinal Disease	☐ Y ☐ N

Cancer ☐ Y ☐ N If yes, what type? ______________________

Radiation ☐ Y ☐ N If yes, provide the name and date of initial start and completion of treatment: ______

____

Chemotherapy ☐ Y ☐ N If yes, provide the name and date of initial start and completion of treatment: ______

____

List all lifetime surgeries and dates (if known): ______________________

____

____

____

____

Approved. Effective 05.07.2019

UNIVERSITY RADIOLOGY

Patient Information

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First Name: ______________________

Date of Birth: ______________________

List any hospitalizations you may have had: ______________________

____

____

____

____

Medical History: Allergies (please select all that apply)

Food	☐ Y ☐ N	If yes, describe: ______		Reaction: ______
Food	☐ Y ☐ N	If yes, describe: ______		Reaction: ______
Medication(s)	☐ Y ☐ N	If yes, describe: ______		Reaction: ______
Medication(s)	☐ Y ☐ N	If yes, describe: ______		Reaction: ______
Latex	☐ Y ☐ N	If yes, describe: ______		Reaction: ______
IV Contrast/Dye	☐ Y ☐ N	If yes, describe: ______	☐ CT ☐ MRI	Reaction: ______

Medical History: Current Medications (please list all that apply)

Medication / Dosage: ______	Medication / Dosage: ______
Medication / Dosage: ______	Medication / Dosage: ______
Medication / Dosage: ______	Medication / Dosage: ______
Medication / Dosage: ______	Medication / Dosage: ______
Medication / Dosage: ______	Medication / Dosage: ______
Medication / Dosage: ______	Medication / Dosage: ______

Social History (please select all that apply):

Do you or have you ever smoked? ☐ Y ☐ N If yes, how much? ______ ppd / ______ years

Do you drink? ☐ Y ☐ N If yes, how much? ______

What do you do for a living? ______

Family History (please select all that apply):

	Mother	Father	Sibling
Cancer	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Coronary Disease	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Kidney Disease	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Congenital Diseases	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Aneurysms	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Diabetes	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Asthma	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Other (please list): ______________________

____

Female Patients: Date of last menstrual period ______ Are you trying to get pregnant? ☐ Y ☐ N

Approved. Effective 05.07.2019

PATIENT CONSENT TO DISCLOSE MEDICAL INFORMATION TO DESIGNEES

I, ____ authorize University Radiology Group to disclose my health information to the individuals listed below:

I understand that my designees will be required to provide photo identification when requesting my health information.

In addition to the individuals listed below, I acknowledge that University Radiology Group may share my health information with my healthcare provider or as otherwise required by law.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act ("HIPAA"). I understand that I have the right to revoke this authorization or change the list of designated individuals at any time by mailing a letter expressly stating this fact and including my name, address, telephone number and my signature and that I should send it to:

University Radiology Group
579A Cranbury Road
East Brunswick, NJ 08816
Attn: Privacy Officer

Such cancellation or change in authorization shall be effective as of the date of University Radiology Group's receipt of my letter cancelling or modifying my authorization.

Designated Individuals:

Print Name	Relationship to Patient
Print Name	Relationship to Patient

Patient Information:

Patient's Signature	Patient's Date of Birth
Patient's Telephone Number	Date of Authorization

UNIVERSITY RADIOLOGY

ADVANCED IMAGING SUPPLIERS NOTICE

You are receiving this noticed because a University Radiology Group (URG) physician has ordered one or more of the following advanced imaging service(s): magnetic resonance imaging, computed tomography, or positron emission tomography.

Please be advised that you may receive these service(s) from URG or a person or entity *other than* URG.

The following are five (5) other suppliers of these service(s) within a 25-mile radius of the current URG location, in no particular order:

	Supplier Name	Address	Telephone
1	Edison Imaging at JFK Medical Center	60 James St. Edison, NJ 08820	732-632-1650
2	MRI of Woodbridge	1500 St Georges Ave, Avenel, NJ 07001	732-574-1414
3	Woodbridge Radiology	530 Green St, Iselin, NJ 08830	732-326-1515
4	Princeton Radiology, Freehold	901 W Main St, Freehold, NJ 07728	732-462-4844
5	Princeton Radiology, Marlboro	176 Rt 9 N, Marlboro, NJ 07726	732-577-2750

By signing below, you acknowledge receipt of this notice.

Patient / Patient's Representative Signature

Date

**If signed by Individual's Representative, please print name and describe the nature of authority that enables you to sign for the individual:

Representative Name

Nature of Authority of Representative