

PHYSICIANS MRI, LLP

Caritas Medical Arts Building
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PODIATRIC PRESCRIPTION PAD

Patient's Name: _____ Date: _____

Referred by: _____ Tel. #: _____

Clinical & Surgical History: _____

Diabetes? Yes No Trauma (when)? _____

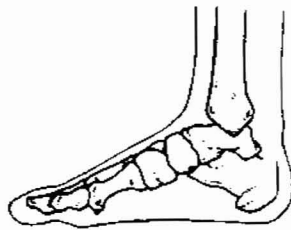
Diagnostic Question (write in or check off any that may apply) _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Fracture/stress fracture/contusion | <input type="checkbox"/> Tendonopathy or Tear (specify) _____ | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Lisfranc Fracture | <input type="checkbox"/> Ligament tear or sprain _____ | <input type="checkbox"/> Plantar Fibromatosis |
| <input type="checkbox"/> Overuse | <input type="checkbox"/> Sinus Tarsi Syndrome | <input type="checkbox"/> Sesamoiditis |
| <input type="checkbox"/> Osteochondritis Dissecans | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Os Trigonitis |
| <input type="checkbox"/> Avascular Necrosis | <input type="checkbox"/> Neuroarthropathy, Charcot Foot | <input type="checkbox"/> Bone Tumor |
| <input type="checkbox"/> Reflex Sympathetic Dystrophy | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Soft Tissue Mass |
| <input type="checkbox"/> Tarsal Coalition (specify if possible) _____ | <input type="checkbox"/> Seronegative Arthropathy | <input type="checkbox"/> Morton Neuroma |
| <input type="checkbox"/> Hallux Valgus/Bunion | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Entrapment Neuropathy |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Tarsal Tunnel Syndrome |

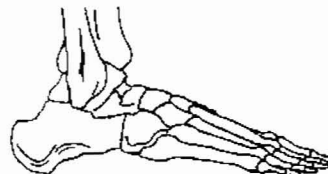
Identify the location of suspected pathology



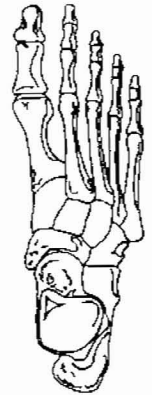
plantar



medial



lateral



dorsal

We would be grateful for the opportunity to review any pertinent imaging studies which the patient can provide at the time of our examination.

MRI

- | | | |
|--|--------------------------------|-------------------------------|
| <input type="checkbox"/> Ankle/Hindfoot | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Midfoot | <input type="checkbox"/> right | <input type="checkbox"/> left |
| (navicular, cuboid, cuneiforms, joint of Lisfranc) | | |
| <input type="checkbox"/> Metatarsals-toes | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Intravenous Gadolinium if indicated | | |

Physician Signature: _____