[YOUR LOGO HERE]

EXAM REQUISITION

  X-RAY  CT MRI  US NUCLEAR MEDICINE

  PET  PET/CT  DEXA  MRA MAMMOGRAPHY

 ORGAN SYSTEM(S) TO BE EXAMINED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL REQUESTS

 Send films by courier

 Send films w/patient

 Call w/appointment time

 Fax w/appointment time

 Courier w/appointment time

 Call if patient reschedules

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Send copy of report to:
 Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician contact number
for urgent findings:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician after hours/weekend #:
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone: (Day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV Contrast may be used at the discretion of the radiologist: YES  NO

Clinical Information/Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BUN: \_\_\_\_\_\_\_\_\_\_\_\_\_ Creatine: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware if the patient has M. Tuberculosis? YES  NO

Does the patient have a pacemaker? YES  NO

Appointment Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Instructions:**

Patient should arrive \_\_\_\_\_\_ minutes prior to appointment time.  CT or MRI patients will be contacted by staff prior to exam for additional questions. If not contacted by 3:00 pm one day prior to CT or MRI exam, please call XXX-XXX-XXXX. Detailed information about your exam is provided by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Thank you.

Women of childbearing ages (12-55 years) **SHOULD** be screened for the possibility of **PREGNANCY** before scheduling diagnostic, CT, and/or MRI procedures.

[INSERT MAP HERE]

Patient Information Web Site:

[INSERT LOCATION]



[INSERT PARKING

INSTRUCTIONS]

For additional information visit:

[PLACE YOUR

WEB SITE HERE]

IMAGING CENTER: **Phone (XXX) XXX-XXXX** SCHEDULING: **Phone (XXX) XXX-XXXX Fax (XXX) XXX-XXXX**

 Payment is required at the time of service unless other arrangements have been made.