

[YOUR LOGO HERE]

EXAM REQUISITION

- X-RAY CT MRI US NUCLEAR MEDICINE
 PET PET/CT DEXA MRA MAMMOGRAPHY

ORGAN SYSTEM(S) TO BE EXAMINED _____

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: _____

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 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 LOCATION]

[INSERT MAP HERE]

Patient Information Web Site:

RADIOLOGYINFO.ORG
The radiology information resource for patients
 La fuente de información sobre radiología para pacientes

[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.