[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: _____

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: _____

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
For patients
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.