

Please complete and fax to the appropriate department. MUST fill in all areas marked with *.
Please Fax to (603) 650-6353 and then call to schedule at (603) 650-8445

FAX Numbers
 DX Radiology (603) 653-0581
 Mammo & DXA (603) 653-6141
 CT and MRI (603) 650-6353
 Nuc Med (603) 650-6353

PATIENT INFORMATION

*PATIENT NAME _____ *DOB _____

PATIENT ON PRECAUTIONS PATIENT IS OR MAY BE PREGNANT MRN _____

O2 DIABETES CLAUSTROPHOBIA SEDATION _____

WHEELCHAIR OTHER MOBILITY ISSUES _____

*INSURANCE AUTHORIZATION # _____ *EXPIRATION DATE _____

* NO PRECERTIFICATION REQUIRED

OTHER PATIENT NOTES

ORDER REQUEST DETAILS DX CT MRI Contrast _____

All contrast requests will be reviewed by the Radiologist

How soon is scan needed? _____

*CLINICAL HISTORY _____ * ICD 10 CODE _____

_____ *PART TO BE EXAMINED _____

_____ _____

*REASON FOR EXAM _____ COMMENTS _____

_____ _____

_____ _____

NUC MED please fill in specific information PET SCANS USE SEPARATE PET SCAN FORM

BONE SCAN WHOLE BODY LIMITED THREE PHASE VQ LUNG PROFUSION

SENTINEL NODE INJECTION W/SCAN W/OUT SCAN SENTINEL NODE BREAST

THYROID SCAN _____ RENAL SCAN-OBSTRUCTION RENAL SCAN-FUNCTION

CARDIAC STRESS exercise CARDIAC STRESS non-exercise

Other NUC MED STUDY _____

REFERRING PROVIDER

Physician Signature _____ Date/Time _____

Print Physician Name _____ Pager or Phone# _____