DIAGNOSTIC RADIOLOGY

Dartmouth-Hitchcock MEDICAL CENTER

IMAGING REQUEST FORM

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# _____