

IMAGING REQUEST

Please complete and fax to the appropriate scheduler (see fax information at lower left.)
 For telephone assistant: (603)-650-4488

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Special Considerations: _____ MRN: _____

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Blind | <input type="checkbox"/> O ² |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Precautions |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Stretcher Needed |
| <input type="checkbox"/> IV | <input type="checkbox"/> Wheelchair Needed |

Notes: _____

INDICATION / REQUEST DETAILS (*Required)

Body Part to be Examined*: _____

Laterality*: _____ ICD 10 Code*: _____

Diagnosis*: _____

Reason for Exam*: _____

Pre-Auth Number*: _____

Other Pertinent Information: _____

Special Medical Equipment Needed: _____

Order for*:

- STAT**
 Today
 Pre-Op: _____

Modality*:

- DX NUC MED
 CT Ultrasound
 MRI Other: _____

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

Ordering Provider Signature: _____

- Staff Physician
 Resident/Other

Date: ____/____/____

FAX NUMBERS

CT*	(603)-650-3526
Diagnostic X-Ray	(603)-653-0581
Mammography and DXA*	(603)-640-1944
MRI*, Nuclear Medicine	(603)-650-6353
Ultrasound	(603)-640-1944
VIR (Angiography)	(603)-650-7483

PHONE NUMBERS

CT	(603)-650-7452
Diagnostic X-Ray	(603)-650-4482
Mammography and DXA	(603)-650-8260
MRI	(603)-650-8445
Nuclear Medicine	(603)-650-5560
Ultrasound	(603)-640-7451
VIR (Angiography)	(603)-650-7464

NOTES (DEPT. OF RADIOLOGY USE ONLY):

*CT, MRI, and Mammography orders need to include safety questions.