Scheduler_____ Date & Time of Exam _____

DIAGNOSTIC RADIOLOGY & IMAGING CT INFORMATION SHEET

Patient Name: _____DOB: _____AGE: _____

Home#: _____Work#: _____SS#:_____

Patient Height: _____Weight:_____Ins: _____

Referring Doctor: _____Contact: _____

Phone:_____Fax: _____Call Report: NO YES

TYPE OF CT REQUESTED

Head WO	Chest With CM	Lumbar
Head W/WO	Chest WO CM	Cervical (Level_____)
Sinus	Ltd Chest	Thoracic (Level_____)
Ltd Sinus	Abdomen ____ ORAL CONTRAST	Soft Tissue Neck
Temporal Bone	Pelvis ____ ORAL CONTRAST	Upr Extremity
Orbits	Multi Reconstruct	Lwr Extremity

Other: _____Plain Films: _____

Reason for Study: _____

If the patient is Diabetic or at Age 55 or Older, Renal Functions must be done.
These results must be dated within 3 months of the testing date.

Patient is Diabetic _____ Patient is Age 55+_____

Diabetic Medications:_____ No Meds _____

Allergies:_____

Renal Functions: BUN _____CREATINE_____Date Labs Drawn: _____

Surgery on the Part of the Body to be Studied? No Yes
If yes, When/Where _____
Prior Studies on the Part of the Body to be Studied? No Yes
Type of Study: Xray CT MRI US BONE SCAN IVP/KUP
Location of Study: _____
Spoke to: _____Date/Time:_____
Spoke to: _____Date/Time:_____

Films & Reports By: Patient Courier No Previous Films_____