RADIOLOGY REQUISITION AND ORDERS

Fax Order to: (617) 243-6776    Central Scheduling hours: Monday to Friday 8.00am to 6.00pm    (617) 243-6800

Clinical History:

Indication (Reason for examination):

Diagnosis:

Stat reading required:  □ YES  □ NO  Call to:  Phone:  Pager:

Radiology
Exam Ordered:  □ Left  □ Right  □ Bilateral

Bone Densitometry
Exam Ordered:  □ Axial  □ Peripheral

CT Scan or IVP
Exam Ordered:  □ Left  □ Right  □ Bilateral

Any contraindications to contrast?__________________________

Serum Creatinine__________________________

(Required if age 55 or older)

1. Is there a history of reaction to contrast material (excluding nausea, vomiting, sensation of heat or flushing)?_________  □ YES  □ NO
   If yes, when and what were the symptoms?__________________________
   Is there a history of anaphylactoid (including hives) or anaphylactic reaction to contrast material?__________________________  □ YES  □ NO

2. Is there a history of asthma? If yes, patient must bring inhaler_________  □ YES  □ NO

3. Is there a history of kidney failure or kidney surgery?__________________________  □ YES  □ NO

4. Is there a history of multiple myeloma?__________________________  □ YES  □ NO

5. Is there a history of sickle cell anemia?__________________________  □ YES  □ NO

6. Is the patient taking Glucophage or metformin?__________________________  □ YES  □ NO

7. Is there a history of recent dehydration?__________________________  □ YES  □ NO

8. Is there a history of Diabetes Mellitus?__________________________  □ YES  □ NO

* Contact the Radiology Department to discuss need for IV contrast and/or pre-medication.

Nuclear Medicine
Exam Ordered:

Ultrasound
Exam Ordered:  □ Left  □ Right  □ Bilateral

Mammogram: Use Women’s Imaging Center Order Form

Physician’s Signature: ____________________________ Date: ____________________________