NEWTON-WELLESLEY HOSPITAL

PATIENT IDENTIFICATION AREA

Name: DOB

Address:

City/St./Zip

Telephone:

SSN:

RADIOLOGY REQUISITION AND ORDERS

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

DATE	TIME	Ordering Provider:
		Copies to MD:

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:** ______________