BRIGHAM AND WOMEN'S
Faulkner Hospital

RADIOLOGY EXAM REQUISITION

Radiology Scheduling Tel. #617-983-7020 Fax #617-983-7633
Sagoff Mammography Tel. #617-983-7272 Fax #617-983-7091

PATIENT NAME: _____ **DOB:** ____/____/____

APPOINTMENT DATE: _____ **TIME:** _____

ORDERING PHYSICIAN: _____
(please print)

NPI #: _____ **PHONE/PAGER:** _____

EXAM INFORMATION **(please check appropriate boxes below and fill in the blank lines)**

Modality:

☐ Diagnostic X-Ray ☐ CT ☐ MRI ☐ Ultrasound
☐ Nuclear Medicine ☐ Mammography ☐ Special Procedure

Laterality: ☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable

Body Part/Test Ordered: _____

For CT/MR Exams: ☐ **With Contrast*** ☐ **Without Contrast** ☐ **With & Without Contrast***

Creatinine: _____ **GFR:** _____ **Date of Labs:** _____

* Labs to assess GFR (glomerular filtration rate) will be ordered under ordering physician's name if deemed necessary per department policy/protocol. To "Opt Out" please check box below.

☐ Please DO NOT order labs on my patient. Contact me at _____ if labs are necessary.

Signs/Symptoms: _____
("Rule Out" is not acceptable without accompanying signs/symptoms)

Differential Diagnosis: _____

Prior Authorizations: If you are ordering a CT, MRI, or Nuclear Cardiology exam, please check with payor if a pre-authorization number is required.

Prior Authorization #: _____ **CPT(s) Approved:** _____

☐ **Not Required**

MD SIGNATURE: _____ **DATE:** _____ **TIME:** _____