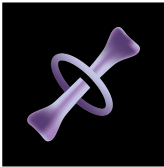

University Hospital
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corkxray@corkradiologistsgroup.com

PRIVATE IMAGING REQUEST FORM

PATIENT DETAILS:

NAME

DOB

MRN

ADDRESS

TEL

CLINICAL INFORMATION / QUESTION

ANATOMICAL AREA TO BE IMAGED:

Type of Imaging Requested:

☐ CT
☐ CBCT
☐ FLUOROSCOPY
☐ ULTRASOUND
☐ X-RAY
☐ IMAGE GUIDED INJECTION / BIOPSY
☐ NUCLEAR MEDICINE
☐ VASCULAR INTERVENTION

ALLERGIES :

DIABETES : Y / N

LMP:

REFERRER DETAILS:

SIGNED: **DATE:**

NAME:

ACCEPTED BY:

ADDRESS FOR REPORT:

TEL / FAX

APPOINTMENT TIME:

PP