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# PRIVATE IMAGING REQUEST FORM

## PATIENT DETAILS:

NAME _____

DOB _____

MRN _____ M ☐ F ☐

ADDRESS _____

_____

_____

TEL _____

## CLINICAL INFORMATION / HISTORY / QUERY

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## ANATOMICAL AREA TO BE IMAGED:

_____

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**Type of Imaging Requested:**

☐ CT ☐ CBCT/OPG ☐ FLUOROSCOPY ☐ ULTRASOUND ☐ MAMMOGRAPHY

☐ X-RAY ☐ INJECTION / BIOPSY ☐ NUCLEAR MEDICINE ☐ VASCULAR INTERVENTION ☐ BARIUM EXAM

REFERRING DOCTOR: _____

ADDRESS FOR REPORT: _____

_____

TEL/FAX FOR REPORT: _____

SIGNED: _____ DATE: _____

ALLERGIES: DIABETES: Y/N _____

LMP: _____

ACCEPTED BY: _____

APPOINTMENT DATE/TIME: _____

PATIENT PROTOCOL CHECK ☐