

DEPARTMENT OF DIAGNOSTIC IMAGING
NEWPORT HOSPITAL

CT IMAGING REQUEST FORM

TO SCHEDULE CALL - 1-866-4UR-XRAY OR FAX-401-848-6008
(1-866-487-9729)

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

MR#: _____ Phone # (Home) _____ (Work) _____

Healthcare Plan(s) _____ Number(s) _____

CT EXAMS REQUESTED:

Head Sinus Orbit Facial Bone Neck
Chest Abdomen Pelvis _____ _____

I give approval for patient to receive IV iodinated contrast material***

<p>*** Allergies: _____</p> <p>Does the patient have a history of?</p> <table><tr><td>Heart Disease</td><td>Kidney Disease</td></tr><tr><td>Asthma</td><td>Diabetes</td></tr><tr><td>Liver Disease</td><td>If yes, do they take</td><td>Glucophage/Metformin or</td><td>Glucovance?</td></tr><tr><td>Hypertension</td><td></td><td></td><td></td></tr></table> <p>What is the patient's? BUN _____ Creatinine _____</p>	Heart Disease	Kidney Disease	Asthma	Diabetes	Liver Disease	If yes, do they take	Glucophage/Metformin or	Glucovance?	Hypertension			
Heart Disease	Kidney Disease											
Asthma	Diabetes											
Liver Disease	If yes, do they take	Glucophage/Metformin or	Glucovance?									
Hypertension												

REQUIRED PATIENT'S HISTORY:

Pertinent Medical/Surgical History: _____

ORDERING INFORMATION:

Date of Request: _____

Requesting Physician: _____ Attending Physician: _____

Requesting Physician's Phone or Pager #: _____

Name of Person Taking Request if ordered By Phone: _____

REQUIRED SIGNATURE OF REQUESTING PHYSICIAN: _____

Date: _____