



DEPARTMENT OF DIAGNOSTIC IMAGING  
NEWPORT HOSPITAL

**NUCLEAR MEDICINE REQUEST FORM**  
TO SCHEDULE CALL - 1-866-4UR-XRAY OR FAX-401-845-1768  
(1-866-487-9729)

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

MR#: \_\_\_\_\_ Phone # (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Healthcare Plan(s) \_\_\_\_\_ Number(s) \_\_\_\_\_

**NUCLEAR MEDICINE SCAN REQUESTED:**

Bone Scan Whole Body                      Bone Scan 3-phase \_\_\_\_\_ site? \_\_\_\_\_

Lung Scan (V/Q)

*Approval for ordering correlative x-ray if necessary*

Thyroid Uptake and Scan                      Biliary (HIDA) \_\_\_\_\_

Renal Scan with Lasix                      Renal Scan without Lasix                      Renal Scan-Captopril

Gallium Scan for Tumor Localization                      Gallium Scan for Abscess Localization

Cardiolite                      Thallium                      Other Cardiac \_\_\_\_\_

Bone Densitometry

**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: \_\_\_\_\_