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MUSC Health

RADIOREQST

RADIOLOGY REQUEST FORM

Form Origination Date: 8/01
Version: 9 Version Date: 11/09

This form may be completed on line. Tab or move cursor to text field and type in text.
For HIPAA Compliance reasons, this form IS NOT TO BE SAVED with patient information. Selecting the PRINT button will clear all information from the note.

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

I. ☐ INPATIENT Room _____ ☐ OUTPATIENT
☐ Today ☐ First Available
☐ Other. Date exam desired: _____ ☐ AM ☐ PM

II: Portable ☐ Yes ☐ No (Xrays only)
Check the appropriate box:
☐ Category I Life Threatening (Chest only)
☐ Category II Urgent Symptomatic Patient
☐ Category III Timely Asymptomatic Patient

III. Check modality choice

	☐ Diagnostic	☐ Peds	☐ CT	☐ Ultrasound	☐ Mammo	☐ MRI	☐ Nuclear	☐ Interventional	☐ Neurointerventional Angio/Embo	☐ NeuroInterventional LP/Myelo/Spine	☐ Bone Density	☐ Rutledge Tower (Diagnostics)
MUH/ART Outpt Phone	2-9729	2-9729	2-9729	2-9729	2-8439	2-9729	2-6932	2-9271	2-6398	2-9729	2-9729	6-0222
MUH/ART Outpt Fax	2-9364	2-9364	2-9364	2-9364	6-0233	2-9364	2-1746	2-2672	2-6359	2-9364	2-9364	6-1006
MUH Inpt Phone	2-7450	2-7435	2-7445	2-3045	2-8439	2-4436	2-6932	2-7456	2-6398	2-6398	6-0227	
MUH Inpt Fax	2-4118	2-6414	2-5856	2-9185	6-0233	2-1502	2-1746	2-5551	2-6359	2-6359	2-9364	
ART Inpt Phone	6-7130		6-7133	6-7141		6-7144	6-7115	6-5542		6-7130		
ART Inpt Fax	6-7189		6-7191	6-4923		6-7193	6-4292	6-5577		6-7189		

IV. REQUEST WILL NOT BE ACCEPTED WITHOUT REQUIRED INFORMATION AND WILL BE RETURNED TO REQUESTOR IF ITEMS 1 THROUGH 7 ARE NOT COMPLETED

1) Exam ordered: _____
(Note: A written order in the medical record is required.)

2) Clinical indications: (List signs & symptoms that reflect medical necessity and enter these signs and symptoms in patient's medical record.)
UNACCEPTABLE INDICATIONS: "Line/Tube Placement, Pre-Op, Follow-Up, Status-Post, or Rule-Out"

_____
_____

3) History: _____

4) Requesting Provider: _____ _____ _____ _____
Last Name, First Name, Credentials Pager ID Phone Date

5) Attending Physician: _____ _____ _____
(if different from requestor) Last Name, First Name Pager ID Phone

6) Request Form completed by (if different from above): _____
Last Name, First Name, Title

7) Patient Information for non-invasive studies:

Sedation Needed: ☐ Yes ☐ No
☐ Adult Oral (Nursing provides)
☐ Adult IV (Anesthesia provides)
☐ Pediatrics (Anesthesia provides)

Isolation Precautions: ☐ Yes ☐ No
☐ Respiratory ☐ Contact Isolation

Contrasted Study: ☐ Yes ☐ No
Creatinine _____
Contrast Allergy: ☐ Yes ☐ No
Premedication Ordered: ☐ Yes ☐ No
Possible Pregnancy: ☐ Yes ☐ No

Radiology Office Use
ACCESSION NO: _____ _____ _____
Technologist Date/time complete
PROTOCOL: _____

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