

OUTPATIENT

REQUEST FOR RADIOLOGIC CONSULTATION

| | |
|-------------------------|---|
| EXAMINATIONS REQUESTED: | <input type="checkbox"/> COMPUTER CONFIRMED |
| | DATE |
| | 1. |
| | 2. |
| 3. | |
| 4. | |

NAME
(Last, First, Middle Initial)

History
Number

Sex

Birth
Date

PERTINENT CLINICAL DATA

ICD-9:

CALL REPORT EXT. _____

SEND FILMS

PHYSICIAN'S SIGNATURE _____

COPY REPORT TO:

ADDRESS _____
Please print name and address if not at HUP

PHONE # _____

SPECIAL INSTRUCTIONS (Include if Pregnancy Suspected):



HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA

DEPARTMENT OF RADIOLOGY

OUTPATIENT RADIOLOGY APPOINTMENT SLIP

IN ORDER TO SAVE YOU TIME PLEASE FILL IN THE FOLLOWING BEFORE REPORTING FOR YOUR APPOINTMENT.

Last

First

Middle Initial

NAME:

ADDRESS:

REPORT TO



- SILVERSTEIN RADIOLOGY
(1st Floor Silverstein)
or
- MAIN RADIOLOGY
(Ground Dulles Building)
or
- PENN TOWER
(Bridge Level)
or
- MRI CENTER
(Ground Founder Building)

DATE:

TIME:

Type of Insurance:

PLEASE ARRIVE 10 MINUTES BEFORE YOUR APPOINTMENT. IF UNABLE TO KEEP THIS APPOINTMENT CALL 662-3000 AT LEAST 24 HOURS BEFORE.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
DEPARTMENT OF RADIOLOGY

073940-1

AEL 11/2006

_____ Demographic info correct in system

_____ patient taken down to the scanner

VERIFIED COPY
NAME _____

Date _____