Beth Israel Lahey Health
Beth Israel Deaconess Milton

Office Use Only:
Date of Exam: _____ Time: _____

Radiology Requisition

Scheduling Phone Number: **617-313-1140**

Scheduling Fax Number: **617-313-1555**

DOB: ____/____/_____

Patient Name: _____

Insurance: _____

Pre-authorization #: _____

Pre-Auth Effective Dates: _____

Date of Request: _____

Modality:

☐ **X-ray/Fluoroscopy** ☐ **CT Scan*** ☐ **MRI*** ☐ **Ultrasound** ☐ **Nuclear Medicine**
☐ **Bone Density (DEXA)**
☐ **Breast Imaging-**☐ **Screening Mammogram** ☐ **Diagnostic Mammogram** ☐ **Breast Ultrasound)**
☐ **Other**

Type and Area of Exam(s) Requested (Please be specific): _____

Laterality (if appropriate): ☐ Left ☐ Right ☐ Bilateral

If CT or MRI*:

☐ With Contrast* ☐ Without contrast ☐ With and Without contrast* ☐ Consult with Radiologist

***Lab Results if within past 30 days (for contrast CT or MRI):**

Creatinine: _____ Date Resulted: _____

Does this patient have an allergy to contrast media or any contraindication to receiving contrast media?
☐ Yes ☐ No

If MRI ordered, any history of pacemaker, metal implants or claustrophobia? ☐ Yes ☐ No

Clinical History (Please give specific signs and symptoms and primary clinical concern: ***Please do not use "Rule Out (R/O) or "Pre-Op".*** _____

_____

_____

Pregnancy Status: ☐ Yes ☐ No ☐ Unknown ☐ **Not Applicable**

Referring Clinician Print: _____ **Phone Number:** _____

Referring Clinician Signature: _____ **Pager (if applicable):** _____

☐ IMMEDIATE/WET READ RESULT REQUESTED **Results Called To:** _____
(Phone Number)

Revision Date: 12/12/2022