Name **MRN** **DOB** Patient Identification	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Radiology Outside Imaging Order**

Patient Information: *(Must be completed)*

Location: ____Inpatient ____Outpatient ____ED Patient

Urgency: ____Life Threatening (within 1 hour) ____Urgent Read (within 8 hours) ____Routine Read

Current Image Location: ____CD ____Emix

CD Disposition: Hold for pick up (Held 7 days) ____ Return to PO Box # _____ Discard____

STUDIES FOR CD IMPORT:

INDICATE THE *NUMBER OF STUDIES* TO BE IMPORTED AND IF CONSULT IS NEEDED OR NO READ IMPORT, A RADIOLOGY ACCESSION NUMBER IS REQUIRED FOR EACH INDIVIDUAL STUDY.

Study Type	No Read	Consult	Study Type	No Read	Consult	Study Type	No Read	Consult
Head CT			Head MRI			Chest Film		
Spine CT			Spine MRI			Bone Film		
Chest CT			Chest MRI			Ultrasound		
Abdomen CT			Abdomen MRI			Angio Study		
Pelvis CT			Pelvis MRI			Nuclear Medicine		
Bone CT			Bone MRI			Other		

If Reading is required, a second opinion is being requested because (Check One):

	Disagreement with outside report
	Clinical presentation not consistent with report
	Concerned about an alternative diagnosis
	Further evaluation needed of the extent of disease or staging
	Further information needed to assist in treatment decisions or surgical planning
	Other indication, please explain:

Working Diagnosis/Presenting Problems:_____

_____

_____

IF RADIOLOGIST INTERPRETATION IS REQUESTED, THE PATIENT WILL BE BILLED FOR THIS SERVICE.

Requesting Physician Name: _____ Physician Pager #:_____

Requesting Physician Signature: _____

Contact Person:_____ Contact Phone #: _____