EISENHOWER IMAGING CENTER

Fax 760.837.8650

CLEAR FORM

IMAGE REQUEST FORM

Requestor _____ Date of Request _____

Telephone _____ Time of Request _____

Patient Name _____ Date of Birth _____

Date Procedure Performed _____ MR # _____

Procedure Requested ○ CT ○ MR ○ MR ○ US ○ NM ○ PET

Format ○ Film ○ CD ○ Paper

Special Instructions _____

_____

_____

☐ **For Pick Up ...** Date of Request** _____

☐ **Deliver to Physicians Office (on EMC campus only) or Pre-Op**

Physician Name _____ Office Location _____

Phone Number _____

☐ **Mail**

TO: Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

☐ **Other** _____

Accepted By _____ **Date** _____

Completed By _____ **Date** _____

RECEIVED BY _____ **DATE** _____

** NOTE: ALL FILM REQUESTS REQUIRE AT LEAST 48 HOURS NOTICE FOR PROCESSING AND PREPARATION.