



Beth Israel Deaconess Hospital
Needham
 Chestnut Street Needham MA
 Telephone () -

OUTPATIENT TESTING REQUISITION
Fax Directly to Testing Area

Patient Name: _____ MR # _____
 Patient Phone: _____ DOB: _____
 Ordering MD: _____ Attending MD: _____
 Insurance Referral Number: _____

RADIOLOGY Fax (781) 453-5789

RADIOLOGY Scheduling Number: (781) 453-3044
(781) 453-3026

REASON FOR EXAM / SIGNS & SYMPTOMS

_____ Year Old Male/Female with:

WET READ <input type="checkbox"/> Yes Phone: _____ Page: _____

Allergies: _____

Pregnant? Yes No

X-Ray

Mammography

Bone Density

CT

Ultrasound

Nuclear Medicine

RADIOLOGY EXAMINATION(S) DESIRED

CLINICAL INDICATIONS FOR RADIOLOGY EXAM (must be complete)

1. _____
2. _____
3. _____
4. _____

1. _____
2. _____
3. _____
4. _____

Bun _____ **Creatinine:** _____ Is this patient on Glucophage/Metformin? Yes No

Last Mammogram Date: _____ Where: _____

ORDER PHYSICIAN

SIGNATURE: _____ **DATE:** _____

Primary Care Physician: _____

Additional Reports To: _____