Dartmouth Health

Dartmouth Hitchcock Medical Center
RADIOLOGY

IMAGING REQUEST: Please complete and fax to the appropriate scheduler (see fax information at lower left.)
For telephone assistance: (603) 650-4488
*This is Part 1 of 2 pages, please make sure to fill out **Part 2- Clinical Decision Support for CT/MRI/NM***

Part 1- IMAGING REQUEST

Patient Name:____ DOB: _____/_____/________

Special Considerations: MRN:____________________________

- ☐ Blind
- ☐ Deaf
- ☐ Diabetic
- ☐ Disoriented
- ☐ IV
- ☐ O^2
- ☐ Pregnant
- ☐ **Precautions**
- ☐ Stretcher Needed
- ☐ Wheelchair Needed

Notes: ____
____
____
____

INDICATION / REQUEST DETAILS (*Required)

Body Part to be Examined*:____________________________________

Laterality*: ____________________________________

ICD 10 Code*: _______________ **Code Description.*:**__________________

Diagnosis*: ____________________________________
____

Reason for Exam*: ____________________________________

Pre-Auth Number*: ____________________________________

Other Pertinent Information: ____________________________________

Special Medical Equipment Needed: ____________________________________

Order for*:

- ☐ STAT (Today)
- ☐ Urgent (1-3 days)
- ☐ ASAP (within 1 week)
- ☐ Pre-Op:________________

Modality*:

- ☐ DX
- ☐ CT
- ☐ MRI
- ☐ NUC MED
- ☐ Ultrasound
- ☐ Other: ________________

REFERRING PROVIDER

Ordering Facility Name: ____________________________________

Ordering Facility Phone #: (_______) - _______ - __________ Provider Pager: _____________

Ordering Provider Name (Print): ____________________________________

Ordering Provider Signature*: ____________________________________

- ☐ Staff Physician
- ☐ Resident/Other

Date: _____/_____/________

FAX NUMBERS

CT*	(603)-640-1956
Diagnostic X-Ray	(603)-640-1967
Mammography / DXA*	(603)-640-1944
MRI*, Nuclear Medicine	(603)-640-1956
Ultrasound	(603)-640-1944
VIR (Angiography)	(603)-640-1966
Fluoro	(603)-640-1965

PHONE NUMBERS

CT	(603)-650-7452
Diagnostic X-Ray	(603)-650-4482
Mammography	(603)-650-8260
DXA	(603)-653-9388
MRI	(603)-650-8445
Nuclear Medicine	(603)-650-5560
Ultrasound	(603)-650-7451
VIR (Angiography)	(603)-650-7464

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Part 2- Clinical Decision Support for CT/MRI/Nuclear Medicine/PET Scans ONLY

Patient Name:____ DOB: _____/_____/________

MRN:____________________________

INDICATION / REQUEST DETAILS (*Required)

Reason for Exam*: ____

Decision Support Session ID*: ____

Decision Support Vendor*: ____

Decision Support Score:

- ☐ 1- Low Utility
- ☐ 2- Low Utility
- ☐ 3- Low Utility
- ☐ 4- Marginal
- ☐ 5- Marginal
- ☐ 6- Marginal
- ☐ 7- Indicated
- ☐ 8- Indicated
- ☐ 9- Indicated

- ☐ Acceptable
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Indeterminate
- ☐ Moderate
- ☐ Not Validated

Decision Support Adherence:

- ☐ No
- ☐ No Criteria Available
- ☐ Yes

For more information visit:
http://nationaldecisionsupport.com/pama/

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