Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

IMAGING REQUEST Part 1

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
- ☐ 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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IMAGING REQUEST Part 2

Please complete and fax to the appropriate scheduler (see **fax** information at **lower left**.)
For telephone assistance: **(603)-650-4488**

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/

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Date: _____/_____/_____

Ordering Provider Name (Print): _____

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