



RADIOLOGY REQUEST

Augusta Health Radiology/CT Department
78 Medical Center Drive
Fishersville, Virginia 22939

Radiology Phone 540-932/332-4400 Fax 540-932/332-4490
CT Phone 540-932/332-4395 Fax 540-932/332-5341

*Required Information

*Patient Name _____ DOB _____

*Requesting Physician _____ Office Phone _____

Scheduled Exam Date _____ **Exam Time** _____

*Exam Type _____
(* NOTE: Please specify "LEFT" or "RIGHT" for any lateralized invasive procedures requested)

*Clinical Indication _____

*IV Contrast: If necessary, can IV contrast be administered?
___ YES ___ NO If NO, please state reason _____

Allergy Premedication: Please contact Radiology for instructions @ 332-4410 or 932-4410

*Exam Status: (If no box is checked, exam will be treated as routine)

___ **Routine** (Final signed reports will be sent to referring physician and available in PACS and EMR. Transcribed draft reports will be available in PACS).

___ **Fax** (Patient will not wait. Test results will be Faxed when complete. Use for non-urgent exams, for which test results are required earlier than available through the routine manner).

Fax _____ Phone _____

___ **Urgent/Wet--Call Report** (Patient must wait until physician is contacted with results. Please use only for urgent exams for acute/critical problems).

Call report to: _____ Phone _____

If after hours, call report to Dr. _____

Pager _____ Phone _____

All reports are available in Dictaphone **immediately** after dictation @ 932 or 332-4676.

*Physician Signature _____