

PATIENT APPOINTMENT

<input type="checkbox"/> AMBUL.	DAY _____
<input type="checkbox"/> WHEEL CHAIR	DATE _____
<input type="checkbox"/> GURNEY	TIME _____
<input type="checkbox"/> $\bar{c}O_2$	LOCATION _____ EXT. _____

PATIENT CARRY STAT EXAMINATION PORTABLE

PRACTICE/LOCATION _____ PHONE: _____

DIAGNOSIS / CLINICAL DATA REQUIRED:

PATIENT PREGNANT? YES NO

ICD 9 CODE REQUIRED:

EXAM REQUESTED:

Special Instructions / Precautions:

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Your signature on this requisition indicates your approval of the use of the drugs and procedures necessary for the examination requested for your patient. For details regarding the preparation of patients and the contraindication of drugs used in examinations, see U.C. Hospital Formulary, NNR, or one of the Radiologists.

UC Attending Physician ID:	NON UC PHYSICIAN Name (Print):
Telephone / Beeper Required:	Address:
Signature Required	
	Zip

ADDITIONAL COPY TO:	ADDITIONAL COPY TO:
UC PROVIDER ID NAME:	UC PROVIDER ID NAME:
ADDRESS/CAMPUS BOX #:	ADDRESS/CAMPUS BOX #:
CITY, STATE, ZIP:	CITY, STATE, ZIP:
TELEPHONE / BEEPER:	TELEPHONE/BEEPER:

RADIOLOGY NOTES

IMMEDIATE READ
Called Time: _____
By: _____
Report Given to: _____

720-002 (Rev. 8/04) WorkflowOne ORIGINAL - MEDICAL RECORD COPY WHITE - DEPARTMENT COPY

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R E F E R R I N G P H Y S I C I A N R A D I O L O G Y

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FAX NUMBER (415) 502-3254