NEW ENGLAND BAPTIST HOSPITAL

DEPARTMENT OF RADIOLOGY
REQUEST FOR DIAGNOSTIC IMAGES
PLEASE FAX TO (617) 754-6463
NEBHRADIOLOGY@NEBH.ORG

Patient Name_____ **Date** _____

Date of Birth _____

Exam(s) Requested _____

Date of Exam(s) _____

PLEASE CHECK ONE: ☐ DVD (Default) ☐ CD (Old PC's)

☐ **I WILL PICK UP MY IMAGES AND REPORT** ** **(IF AVAILABLE)** ***(MUST SHOW PHOTO I.D.)***

- IMAGE SERVICE CENTER HOURS:
  - MONDAY – FRIDAY 8A-4P
- IMAGES MAY BE PICKED UP AT THE MAIN RADIOLOGY RECEPTION DESK LOCATED IN THE CONVERSE BUILDING ON THE 2ND FLOOR
- PLEASE GIVE 24 HOUR NOTICE WHENEVER POSSIBLE

☐ **I AM SENDING A DESIGNEE TO PICK UP MY IMAGES AND REPORT** ** **(IF AVAILABLE)**

DESIGNEE NAME _____
DESIGNEE MUST SHOW PHOTO I.D.

☐ **PLEASE SEND MY IMAGES AND REPORT** ** **(IF AVAILABLE) TO ME/PHYSICIAN:**

_____
(ADDRESS LINE 1)

_____
(ADDRESS LINE 2)

_____
(CITY)

_____
(STATE) **(ZIP CODE)**

_____ **DATE** __/__/__ **| TIME** __:__ **AM/PM**
PATIENT/DESIGNEE SIGNATURE

****ALL REPORTS ARE BURNED ONTO THE IMAGE CD AND WILL NOT BE PRINTED AS A SHEET OF PAPER UNLESS SPECIFICALLY REQUESTED. REPORTS ARE TYPICALLY AVAILABLE WITHIN 24-48 HOURS AFTER IMAGING.**

FOR OFFICE USE ONLY:

Prepared Images _____**(staff initials)** **Date Prepared**_____

Photo I.D. checked at pick-up_____**(staff initials)** Date Mailed_____