BARNES-JEWISH HOSPITAL

BJC HEALTH SYSTEM

DEPARTMENT OF RADIOLOGY
REQUISITION for RADIOLOGIC CONSULTATION

	RADIOLOGY		NUCLEAR MED

RADIOLOGY USE ONLY

BARNES-JEWISH REGISTRATION NUMBER

IDXRAD ACCESSION NUMBER

Birthdate

Social Security Number

Last Name

First Name

RESEARCH STUDY BILL TO NUMBER

RESEARCH STUDY

Maiden Name/Former Name if applicable

ADDRESS

CITY, STATE, ZIP

PHONE

INPATIENT
HOSPITAL LOCATION — PHONE EXTENSION

CLINIC PATIENT
CLINIC LOCATION — PHONE EXTENSION

ER or OUTPATIENT
ER/OUTPATIENT LOCATION — PHONE EXTENSION

REQUESTING M.D. (Please Print)
LAST NAME — FIRST — CONTACT/PAGER NUMBER

M.D. SIGNATURE

REFERRING M.D. (Please Print)
LAST NAME — FIRST — CONTACT/PAGER NUMBER

STAT ORAL REPORT CONTACT #

PREVIOUS FILMS HERE ☐YES ☐NO DATE

IS PATIENT PREGNANT	☐YES	☐NO
IS PATIENT BREAST FEEDING	☐YES	☐NO
IS THERE A COAGULATION PROBLEM	☐YES	☐NO
ARE THERE ALLERGIES or DRUG REACTIONS	☐YES	☐NO
IS THERE A HISTORY OF RENAL DISEASE	☐YES	☐NO

EXAMINATION DESIRED	SPECIFIC REASON FOR EXAMINATION REQUEST/PERTINENT CLINICAL INFORMATION
DATE TO BE DONE:	

SPECIAL INSTRUCTIONS:	RADIOLOGIST USE:

2710-28 (REV 9/98)