Print Form

Virginia Commonwealth University

Department of Radiology

VCU Medical Center

Subspecialty Expertise and Quality Imaging for Better Patient Care

PACS & IMAGING DISTRIBUTION SYSTEM eMix REQUEST

REFERRAL CONTACT INFORMATION:

Date Uploaded: _____ Phone Number: _____

Sending Institution:_____

FAX # : _____ Contact Person:_____

PATIENT INFORMATION:

Name: _____

Alias:_____

DOB: _____ Social Security Number:_____

Address:_____

_____

Telephone Number:_____ Sex: ☐ M ☐ F

Emergency Contact:_____

Patient Employment: ☐ Employed ☐ Retired ☐ Unemployed

Employer:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

PATIENT INSURANCE INFORMATION:

Company: _____Group / Policy Number:_____

Carrier:_____ Relationship to insured:_____

STUDY INFORMATION:

Procedure Type _____

Does this consult import require a Radiologist Reading? Yes ☐ No ☐

IF READING IS REQUIRED, INCLUDE DIAGNOSIS/SYMPTOMS OR SPECIFIC QUESTIONS TO BE ANSWERED FROM THIS INTERPRETATION: _____

_____

_____