VCU Medical Center
Virginia Commonwealth University

DEPARTMENT OF RADIOLOGY
CT REQUEST FORM

Date____/____/_____

Patient Name_____

MR #_____ DOB_____/_____/_____Age_____

Height _____ Weight _____ Gender M F

Please choose location of where exam is to be performed:

☐ ***MCV CAMPUS***
Phone (804) 628-3580
FAX (804) 628-3593

Main Hospital, 3rd Floor
1250 E. Marshall St.
Richmond, VA 23298

Ambulatory Care Center (ACC)
Basement Level
417 N. 11th. St.
Richmond, VA 23298

☐ ***STONY POINT MEDICAL CENTER***
Phone (804) 237-6645
FAX (804) 327-8847

9000 Stony Point Parkway
Richmond, VA 23235

INSURANCE NAME: _____ ***PRE-AUTH. #*** _____ ***BILL INSURANCE?*** ***Y N***

STUDY REQUESTED-DIAGNOSIS-INDICATION-REASON FOR STUDY: (print) _____

_____

***Please specify if any additional information is desired from this exam*: (print)** _____

_____

	BODY/ABDOMEN (CT)		***HEAD / NECK (CT)***		***CONTRAST (please check one):***
☐	Abdominal	☐	Head		☐ With Contrast
☐	Abdominal/Pelvic	☐	Head/TMJ (HTM)		☐ Without Contrast
☐	Chest/Abdominal/Pelvic	☐	Maxillofacial (HMF)		☐ With and Without Contrast
☐	Pelvis (soft tissue)	☐	Neck—soft tissue (HNK)		***PLEASE ANSWER ALL QUESTIONS***
☐	Pelvis (bony)	☐	Orbital (HOR)		***(required for scheduling):***
☐	Chest	☐	Posterior Fossa (HPF)		1. Ambulatory? ☐YES ☐NO
☐	Chest/Abdominal	☐	Sella Turica (HST)		2. Medications? ☐YES ☐NO
☐	Chest/Neck	☐	Sinus	*1 plane* *2 plane*	List Meds (attach list if needed): _____
☐	Liver/Spleen	☐	Temporal Bone (HTB)		_____
☐	Pancreas		***SPINE (CT)***		_____
☐	Renal	☐	Cervical Spine		3. Diabetic? ☐YES ☐NO
☐	OTHER:	☐	Thoracic Spine		Circle if patient is taking any of the following:
	CT ANGIOGRAPHY	☐	Lumbar Spine		Glucophage Glucovance Metaformin
☐	Chest		***EXTREMITY (CT)***		4. Allergies? ☐YES ☐NO (if YES, pre-medicate)
☐	Abdomen	☐	Extremity - Lower	*Left Right Bilateral*	List:_____
☐	Pelvis	☐	Extremity - Upper	*Left Right Bilateral*	5. Sedation? ☐YES ☐NO
☐	OTHER:	☐	OTHER:		6. Anesthesia? ☐YES ☐NO

APPOINTMENT INFORMATION (for Radiology use ONLY)

APPOINTMENT DATE:_____/_____/_____ TIME: _____ AM PM LOCATION: MAIN 3 ACC STONY POINT

APPOINTMENT MADE BY: _____

Signed order required for scheduling:

Referring Physician Name _____ **VM #** _____
(print)

Referring Physician Signature_____

Contact Name _____ **Phone** _____ **FAX**_____ *DRAFT 01-09*