SAINT CLARE'S HOSPITAL

DIAGNOSTIC IMAGING
RADIOLOGY DEPARTMENT

Please Print Clearly

Patient Name: Last _____ First _____

Address: _____

Date of Birth: _____ Phone Number: _____

FACILITY OR PHYSICIAN WHERE FILMS ARE GOING TO:

_____

Which exam(s) would you like? (Please check all that apply)

- ❑ All Films
- ❑ Bone Density(s)
- ❑ Ct Scan (s)
- ❑ Mammogram(s)
- ❑ Nuclear Medicine Scan(s)
- ❑ Relocating / Not Returning Films
- ❑ Ultrasound(s)
- ❑ X-ray(s) _____
- ❑ Reports of exams

❑ I understand that I am being provided with a CD containing image(s) requested and that this CD does not need to be returned to Saint Clare's Hospital, Diagnostic Imaging Department.

❑ I understand that film(s) being provided are copies requested by the physician and that these film(s) does not need to be returned to Saint Clare's Hospital, Diagnostic Imaging Department. If I have previously requested for copies of films, there will be a charge to duplicate them, providing the information is available.

❑ I understand these are original films and must be returned to Saint Clare's Hospital, Diagnostic Imaging Department, with 30 days. If these films are not returned, I understand they will not be available for comparison, which is very important for good medical care. I understand these are original films which must be kept on file at Saint Clare's Hospital as required by law.

Signature: _____ Today's Date: _____

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Print name and relationship of person signing on behalf of patient

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***FOR OFFICE USE ONLY*: Financial/Account Number:** _____

MRN: _____ Signature of Witness: _____