Valiant CLINIC

The future of healthcare, today.

Radiology Request Form

Patient

Full Name: _____

Date of Birth: _____

Sex: ☐F ☐M

Address: _____

_____

Referring Physician

Name: _____

Date: _____

Address: _____

Email: _____

Tel: _____

For Contrast Studies

Creatinine

eGFR _____

Date _____

Diabetes ☐

Asthma ☐

Epilepsy ☐

Renal impairment ☐

Allergy ☐

State allergy _____

Special Considerations:

☐ Interpreter required

☐ Visual/Hearing impairment

☐ Learning disability

☐ Physical impairment/Other

☐ Confusion/Dementia

Transport:

☐ Walk ☐ Chair

Modality:

☐ MRI

☐ CT

☐ X-Ray

☐ Ultrasound

☐ Mammogram

☐ DEXA

☐ Fluoroscopy

Examination Requested: _____

Clinical Indication: _____

_____

Referrer's Signature: _____

Stamp: _____

Smoking History

Smoker ☐

Ex Smoker ☐

Never Smoked ☐

Pregnancy Ruling (female patients up to 55 years)

Is the patient pregnant? Yes ☐ No ☐

If yes and examination still necessary, referring clinician must sign:

Signature _____ LMP _____

For Radiology Use

Previous Imaging: _____

_____

Radiographer: _____

_____

Dose: _____