SVMC - Clay Downtime Imaging Service Request

Please Fax to 602-2705

D/T ACCESSION #:_____

Patient Name:	_____			_____			_____
	LAST			FIRST			MI
DOB:	_____		**ROOM #:**	_____	**MRN:**	_____	
Today's Date:	_____		**Date/Time of Order in chart:**	_____	**Date for this exam:**	_____	
	□ X-RAY	□ TEE					
	□ MRI	□ Echo					
	□ CT	□ Cath					
	□ NUC MED	□ IR	**Order**				
EXAM:	□ Ultrasound	□ Stress	**Description:**				
Ordering Physician:	_____				**PRIORITY:**	**TRANSPORT:**	
Reason for Exam:	_____				□STAT □EXPEDITE	□Wheelchair □Stretcher	
Imaging Services Use Only					□ROUTINE	□Bed □IV	
Examination Performed:	_____				□PORTABLE	□Isolation □O2	
Clinical History							
Date/Time Study Performed			Technologist's Initials		Notes		
# images							

Preliminary Reading

Radiologist:_____ Date/Time:_____

Preliminary result faxed to_____**by**_____**given to**_____**date**_____**time**_____

Preliminary result called to_____**by**_____**given to**_____**date**_____**time**_____

Down Time Recovery

Accession #	
□ **Ordered in cerner (with the correct date/time of the study)**	**Notes:**
□ **Completed in cerner (with the correct date/time of the study)**	
□ **PACS: edited/work listed/exported**	
□ **Documents Scanned**	