

Scheduler \_\_\_\_\_ Date & Time of Exam \_\_\_\_\_

**GREENSBORO IMAGING CT INFORMATION SHEET**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Ins: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Call Report: NO YES

**TYPE OF CT REQUESTED**

Head WO	Chest With CM	Lumbar
Head W/WO	Chest WO CM	Cervical (Level_____)
Sinus	Ltd Chest	Thoracic (Level_____)
Ltd Sinus	Abdomen ____ ORAL CONTRAST	Soft Tissue Neck
Temporal Bone	Pelvis ____ ORAL CONTRAST	Upr Extremity
Orbits	Multi Reconstruct	Lwr Extremity
Other: _____	Plain Films: _____	

Reason for Study: \_\_\_\_\_

*If the patient is Diabetic or at Age 55 or Older, Renal Functions must be done.  
These results must be dated within 3 months of the testing date.*

Patient is Diabetic \_\_\_\_\_ Patient is Age 55+ \_\_\_\_\_

Diabetic Medications: \_\_\_\_\_ No Meds \_\_\_\_\_

Allergies: \_\_\_\_\_

Renal Functions: BUN \_\_\_\_\_ CREATINE \_\_\_\_\_ Date Labs Drawn: \_\_\_\_\_

Surgery on the Part of the Body to be Studied? No Yes  
If yes, When/Where \_\_\_\_\_

Prior Studies on the Part of the Body to be Studied? No Yes

Type of Study: Xray CT MRI US BONE SCAN IVP/KUP

Location of Study: \_\_\_\_\_

Spoke to: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Spoke to: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Films & Reports By: Patient Courier No Previous Films \_\_\_\_\_