Boston Children's Hospital
Department of Radiology

Outside Radiology Requisition

DATE OF REQUEST: ____ /____ /____

MANDATORY PATIENT INFORMATION

Patient Name: ______________________ **MRN:** ______________ **DOB:** _______ /_______ /_______

Parent: ______________________ Patient's Home Phone #: ______________________

Patient's Address: ______________________

Interpreter Needed? (If yes, language): ______________________ Patient Location: ______________________

Labs or Specimens Required: ______________________ ☐ **Patient Identified By:** _______________ **RN/RT/MD Initials**

Is the patient pregnant? ☐ **Yes** ☐ **No** ☐ **Unknown**

Ref. MD Name: ______________________ Ref. MD Signature: ______________________

Ref. MD Phone/Page # ____________________ If requesting MD is not an attending, supply attending name: ______________________

MANDATORY PROCEDURE INFORMATION

1. MODALITY: ☐ **CT** ☐ **MRI** ☐ **Ultrasound** ☐ **Interventional Radiology** ☐ **Nuclear Medicine** ☐ **X-Ray/Fluoroscopy**

2a. Laterality (if appropriate): ☐ **Left** ☐ **Right** ☐ **Bilateral**

2b. Portable? (if appropriate): ☐ **Yes** ☐ **No**

3. Type of Exam – All Parts to be Examined (ex. foot, ankle, tibia, knee – not lower leg)

For CT or MRI body exams: Wt.___________ Ht. ____________

4. Signs & Symptoms [Rule Out (R/O) not acceptable]

5. Prior Treatment / Relevant Drugs / Known Allergies

6. Provisional or Known Diagnosis

a.

b.

c.

FOR CT REQUESTS ONLY

7. Can the patient remain still for 10-15 minutes?

☐ **Yes** ☐ **No**

8. Does the patient have any of the following?

☐ **Contrast reaction** ☐ **Iodine allergy**
☐ **Asthma** ☐ **Renal failure**

FOR MRI REQUESTS ONLY

7. Can the patient remain still for 30-45 minutes?

☐ **Yes** ☐ **No**

8. Does the patient have any implants or devices that may be a contraindication for MRI?

☐ **Yes** ☐ **No**

RADIOLOGY (for Radiologist use only)

PROTOCOL

BCH RADIOLOGY FAX AND PHONE INFO

Radiology Central Scheduling – Fax: 617-730-0857 / Phone: 617-919-7226