Beth Israel Lahey Health
New England Baptist Hospital

DEPARTMENT OF RADIOLOGY
REQUEST FOR DIAGNOSTIC IMAGES

PLEASE FAX TO (617) 754-6463
TEL: 617-754-5289
NEBHRADIOLOGY@NEBH.ORG

Patient Name____ **Date** _______________

Date of Birth _________________________ **MED REC#**____________________

Exam(s) Requested ____

Date of Exam(s) ____

❑ **I WILL PICK UP MY IMAGES AND REPORT** (IF AVAILABLE) *(MUST SHOW PHOTO I.D.)***

- IMAGE SERVICE CENTER HOURS:
  - MONDAY – FRIDAY 8:30A-4P
- IMAGES MAY BE PICKED UP AT THE MAIN RADIOLOGY RECEPTION DESK LOCATED IN THE CONVERSE BUILDING ON THE 2ND FLOOR
- PLEASE GIVE 24 HOUR NOTICE WHENEVER POSSIBLE

❑ **I AM SENDING A DESIGNEE TO PICK UP MY IMAGES AND REPORT** (IF AVAILABLE)**

DESIGNEE NAME _____________________________

*****DESIGNEE MUST SHOW PHOTO I.D.***

❑ **PLEASE SEND MY IMAGES AND REPORT** (IF AVAILABLE) TO ME/PHYSICIAN:**

____

(ADDRESS LINE 1)

____

(ADDRESS LINE 2)

____

(CITY) **(STATE)** **(ZIP CODE)**

___________________________ **DATE** __/__/__ | **TIME** __:__ **AM/PM**

PATIENT/DESIGNEE SIGNATURE

****ALL REPORTS ARE BURNED ONTO THE IMAGE CD AND WILL NOT BE PRINTED AS A SHEET OF PAPER UNLESS SPECIFICALLY REQUESTED. REPORTS ARE TYPICALLY AVAILABLE WITHIN 24-48 HOURS AFTER IMAGING.**

There is a $20.00 fee for each CD payable at:

https://www.nebh.org/billpay

FOR OFFICE USE ONLY:

Prepared Images __________**(staff initials)** **Date Prepared**____________

Photo I.D. checked at pick-up___________**(staff initials)**