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:** _____

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown **RN/RT/MD Initials**

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