# DOWNTIME REQUISITION – IMAGING SERVICES

PLEASE AFFIX PATIENT IDENTIFICATION LABEL HERE, IF AVAILABLE

**FACILITY: MWH SH FSED**
(PLEASE CIRCLE)

**NURSING UNIT/CARE CENTER: _____ FAX #: _____**

***Please complete a separate Downtime Requisition Form for each imaging modality for which you are requesting an exam. Circle the appropriate imaging modality and complete all shaded areas. If available, please affix a patient identification label rather than handwriting patient identification/demographic information.***

**X-RAY CT SCAN MRI ULTRASOUND NUCLEAR MEDICINE INTERVENTIONAL RADIOLOGY MAMMO/DEXA**

**PATIENT'S FULL NAME: _____ ECD #: _____**
LAST FIRST MIDDLE

**DATE: _____ DOB: _____ AGE: _____ SEX: _____ MR#: _____**
MM/DD/YYYY

**PATIENT TYPE: ___IP (ROOM # _____) ___OP ___ED ORDERING MD: _____**

***PROCEDURES ORDERED:***

**ORDER TIME: _____ PRIORITY: □ STAT □ ASAP □ ROUTINE □ OTHER: _____**

| DOWNTIME ACCESSION # | PROCEDURE DESCRIPTION | BP TIME | EP TIME | PR TIME | EXAM ROOM # |
|---|---|---|---|---|---|
| PLEASE AFFIX DOWNTIME ACCESSION NUMBER LABEL HERE | | | | | |
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***PROCEDURE CHANGES (For Cancellations/Additions/Other Changes):***

| DOWNTIME ACCESSION # | DESCRIPTION OF CHANGE/PROCEDURE PERFORMED |
|---|---|
| PLEASE REFERENCE APPROPRIATE ACCESSION NUMBER FROM ABOVE | |
| PLEASE REFERENCE APPROPRIATE ACCESSION NUMBER FROM ABOVE | |

**PROCEDURE REASON: _____**

**PATIENT HISTORY/TECHNOLOGIST NOTES:**

**TECH INITIALS: _____**

**RESULTS FAXED TO/EXT. _____ BY _____ DATE _____ TIME _____**

**PROCEDURES TRACKED IN SYNGO BY _____ DATE _____ TIME _____**

***REV 7/12***