DOWNTIME REQUISITION – IMAGING SERVICES

PLEASE AFFIX PATIENT IDENTIFICATION LABEL HERE, IF AVAILABLE

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

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 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 (Rm. # _____) □ OP □ ED (Rm. # _____) 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					
PLEASE AFFIX DOWNTIME ACCESSION NUMBER LABEL HERE					
PLEASE AFFIX DOWNTIME ACCESSION NUMBER LABEL HERE					
PLEASE AFFIX DOWNTIME ACCESSION NUMBER LABEL HERE					

PROCEDURE REASON: _____

RADIOLOGY USE ONLY BELOW THIS LINE:
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	

PATIENT HISTORY/TECHNOLOGIST NOTES:

RADIOLOGIST WHO PERFORMED PROCEDURE: _____ TECH INITIALS: _____
(FOR INTERVENTIONAL, FLUORO, OTHER CASES THAT REQUIRE RADIOLOGIST INVOLVEMENT IN PROCEDURE ITSELF)
RESULTS FAXED TO/EXT. _____ BY _____ DATE _____ TIME _____
PROCEDURES TRACKED IN SYNGO BY _____ DATE _____ TIME _____
REV 12/15