PRELIMINARY REPORT

MARY WASHINGTON HOSPITAL | **DEPT:**___________________________

PRIORITY:_______________________

RADIOLOGY SERVICES | **EXAM DATE:**_____________________

PATIENT NAME:____

MR #: ________________________ **EXAM:** _________________________ **ACC#:**__________________________

PATIENT LOCATION: **IP** **OP** **ED**

ATTENDING MD:____

ORDERING MD:____

***IF THIS RESULT IS CRITICAL, PLEASE FOLLOW CRITICAL TEST RESULT PROCESS**

RADIOLOGY PRELIMINARY READING: EXAM COMPLETED ON: _____/_____/_____AT:____:____BY:____

EXAM(S):

PRELIMINARY REPORT ONLY. THE DEFINITIVE REPORT WILL FOLLOW.

RADIOLOGIST:____ _______________________

REPORT FAXED TO:____

REPORT FAXED BY:____

DATE/TIME:____