Radiology Referral Cover Letter

Date:

Referring Physician Information

Name:

Clinic/Facility:

Phone:

Fax:

NPI Number:

Patient Information

Full Name:

Date of Birth:

Phone:

Insurance/ID:

Imaging Requested

[ ] X-Ray
[ ] CT Scan
[ ] MRI
[ ] Ultrasound
[ ] Mammography
[ ] DEXA Scan

Body Part/Side:

Clinical Indications

ICD-10 Code(s):

Reason for Study:

Stat/Urgent: [ ] Yes [ ] No

Contrast: [ ] With [ ] Without [ ] Per Radiologist Discretion

Physician Signature