



LOMA LINDA UNIVERSITY  
MEDICAL CENTER

RADIOLOGY REQUEST FORM  
**CT**  
Computerized Tomography

Patient's Name (Last, First)	_____	Date of Birth	_____
Patient's Phone Number	_____	Weight	_____
List Any Allergies	_____	Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Symptoms or Reason for Exam	_____	ICD-10 Code(s)	_____

**PLEASE NOTE:** Procedures will NOT be performed without a complete and signed order.

**HEAD AND NECK**

**CHEST, ABDOMEN AND PELVIS**

**UPPER EXTREMITIES**

**LOWER EXTREMITIES**

**SPINE**

**SPECIAL/MISCELLANEOUS**

Ordering Provider (Print Name and Title)	_____	NPI#	_____
Signature (Required)	_____	Phone	_____
Date	_____	Fax	_____

Please FAX the completed form to 909-558-0141, then call to schedule appointment at 909-558-5533, option 3.

You can place orders and view results faster using [llucarelink.org](http://llucarelink.org). Learn more at:  
<http://lluhconnection.org/loma-linda-university-health-carelink>.