



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	Yes 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 2.

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