RWJBarnabas HEALTH Radiology Downtime Order Requisition

If no Addressograph, complete patient information

Patient Name: _____
(First, Middle, Last)

DOB: ____/____/_____ **Gender:** _____

Account Number: _____ **MRN:** _____

☐ **Outpatient** ☐ **ER Patient** ☐ **Inpatient - Unit:** _____ **Room:** _____**Bed:** _____

For written outpatient orders, attach script

Requesting MD Name: _____

Requesting MD Signature: _____

Order Date: ____/____/____ **Order Time:** _____ **am/pm**

Requested Date: ____/____/____ **Requested Time:** _____ **am/pm**

Precautions:

Pregnant: Yes / No **Isolation: Yes / No** **Allergies:** _____

Radiology Department (One form per department):

☐ **X-Ray** ☐ **Fluoro** ☐ **MRI** ☐ **CT Scan** ☐ **Ultrasound** ☐ **Interventional Radiology**

☐ **Nuclear Medicine** ☐ **PET/CT** ☐ **Breast Imaging** ☐ **Dexa**

Procedure/Test: **Accession#**

_____ _____

_____ _____

_____ _____

Indication: _____

Priority: ☐ **Routine** ☐ **Today** ☐ **STAT** ☐ **Pending Discharge** ☐ **Portable**

Radiology Technologist Only:

Begin Exam: ____/____/____ **Time:** _____ **am/pm** **End Exam:** ____/____/____ **Time:** _____

Performing Technologist: _____
Performing Radiologist: _____
Contrast/Isotope Used: _____ **Contrast/Dose amount:** _____
Contrast/Isotope Used: _____ **Contrast/Dose amount:** _____
Fluoro Time (minutes): _____
CT Radiation Exposure (DLP): _____
Tech Notes: _____

_____