ALASKA NATIVE MEDICAL CENTER

* A C R *

RADIOLOGY IMAGE REQUEST FORM

Please select appropriate box(es) below:

☐ UW Transfer ☐ eMix Transfer ☐ CD Rom

☐ Other:_____

Patient name:_____

DOB:_____ ANMC Chart No.:_____

Exam Date of Exam

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_____

Requesting Provider:_____

Appointment Date/Time:_____

Send to:

Organization/Facility:_____

Physical Address:_____

City, State, Zip:_____

Your Name:_____

Signature:_____

Phone No.:_____ Date:_____

Please complete form and fax to (907)729.2339. Call (907)729.2300 to confirm.

Radiology Staff Only

Date completed:_____ Time completed:_____ Completed by:_____