RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

1 - Medical Record

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	FILM NO.				PREGNANT ☐ YES ☐ NO
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DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

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2 - Physician

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

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3 - Radiology