

ENT Radiology Request Form

Cheyenne Radiology & MRI

(307) 634-7711

Fax: (307) 634-7760

Patient Name: _____ Birthdate: _____

Today's Date: _____

Date Report Needed: _____ Phone report? Y N Phone number: _____

Fax report? Y N Fax number: _____

History/Reason For Exam (please do not use "rule out", "suspected", or other provisional diagnoses): _____

Please circle exam and all techniques desired:

Exam:	CT	MRI			
Area of Interest:					
Sinus	IAC's	S.T. Neck	Brain	Chest	Temporal Bones
Details:	With contrast	Without contrast			
	Axial	Coronal	(3 planes are typically obtained for MRI)		
	Multiplanar	and/or	3D reconstructions		

Other: Barium swallow with / without speech pathology (please circle one)

Special instructions: _____

Referring provider's signature or signature stamp required:
