

VERMONT RADIOLOGISTS REQUISITION
620 HINESBURG RD SOUTH BURLINGTON, VT 05403
PH# 802-863-1249 FAX# 802-863-9979

(CT, X-RAYS, ULTRASOUND)
Radiology Requisition
To be completed by referring physician

Patient Name _____ DOB _____

Patient Ph # _____ Exam Date _____ Wet Read: ___ YES ___ NO

Referring Physician _____ Physician Ph# _____

Ins. _____ ID or
Claim# _____

For WORKMANS COMPENSATION or MVA Please provide:

Ins Company _____ ID _____

City _____ State _____ Zip _____ Ph# _____

Preauthorization Required _____ Auth# _____
Yes/No

Examination (s) Requested:

Clinical Information / Diagnosis / Lab Data:

For CT, BARIUM ENEMA, IVP, UGI:

Diabetic? _____ Glucophage? _____ Possibility of Pregnancy? _____
Yes / No Yes / No Yes / No

**PLEASE HAVE THE PATIENT BRING PREVIOUS X-RAYS FOR
COMPARISSON IF POSSIBLE**