Green Imaging

Fax to:
866 653 0882

If Signed by Physician this will constitute Official Exam Order

Patient Name: _____ DOB: _____

Home/Work/Cell Phones: _____

Email: _____

Exams Requested:

_____

_____

If you are not sure if contrast is indicated, do not specify and radiologist will protocol.

Clinical Information/Diagnosis:

_____

_____

Ordering Physician Information:

Name: Phone:

Fax: Cell:

Email:

Preferred route to receive report: (fax / EMR / secure email link)

Physician Signature: _____

FAX form to 866-653-0882 and we will schedule the exam with patient.
Thank you for your referral!