

E-Z CT REQUEST

T 808-547-6294 • F 808-547-6053



APPOINTMENT

Date _____ / _____ / _____

Time _____ : _____ am pm

REQUESTING PHYSICIAN

PATIENT INFORMATION

Last name _____

First name _____

Home phone _____

Birth Date _____ / _____ / _____

Sex Female Male

Ordering Exam _____

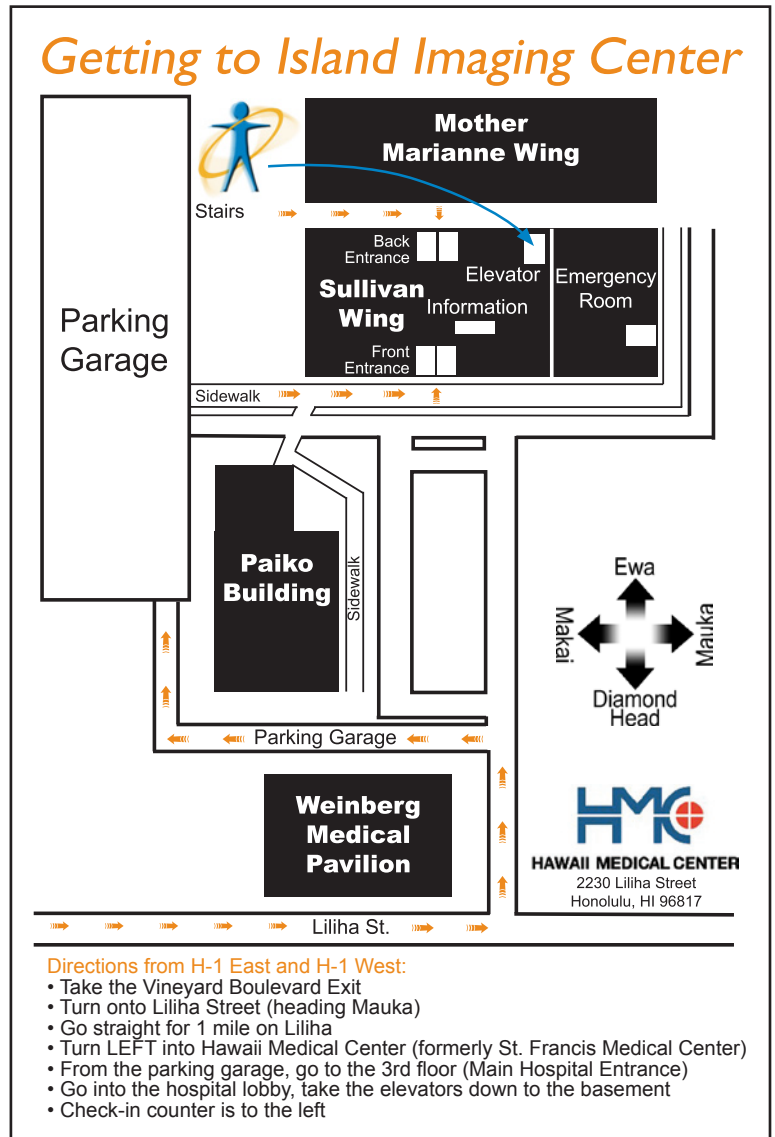
Diagnosis _____

Previous allergy to contrast media
 Yes
 No

Type of reaction _____

History of
 Kidney disease
 Diabetes
 Heart Condition
 Asthmas
 Cancer

If the answer is YES to any of the above
 BUN
 Creatinine
 Date _____ / _____ / _____
 (within 3 months)



PHYSICIANS SIGNATURE _____