URGENT RADIOLOGY INTERPRETATION REQUEST

Date: [Date]

To: [Radiologist Name/Department]
From: [Requesting Physician Name]
Facility: [Facility Name]

PATIENT INFORMATION:
Name: [Patient Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

STUDY DETAILS:
Type of Exam: [e.g., CT Abdomen, Brain MRI, Chest X-Ray]
Date of Exam: [Date of Study]
Accession Number: [Number]

CLINICAL INDICATIONS & URGENCY:
[Briefly describe acute symptoms, suspected diagnosis, or critical findings that require immediate attention.]

SPECIFIC CLINICAL QUESTION:
[State exactly what you need the radiologist to rule out or confirm.]

CONTACT FOR IMMEDIATE NOTIFICATION:
Please provide a verbal report or notification of critical findings to:
Name: [Provider Name]
Phone/Pager: [Phone Number]

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/NPI]