URGENT MEDICAL CARE RADIOLOGY REQUEST

Date: [Insert Date]

To: [Name of Radiology Department/Facility]
Attention: Intake Coordinator / Radiologist

PATIENT INFORMATION:
Patient Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Patient Phone: [Phone Number]

ORDERING PHYSICIAN INFORMATION:
Physician Name: [Doctor's Name]
Clinic/Facility Name: [Clinic Name]
Contact Number: [Phone Number]
Fax Number: [Fax Number]

EXAM REQUESTED: [e.g., X-Ray, CT Scan, MRI, Ultrasound]
Body Part/Site: [e.g., Lumbar Spine, Right Upper Quadrant]

CLINICAL INDICATIONS:
Priority: URGENT / STAT
Reason for Exam: [Briefly describe symptoms and clinical necessity]
ICD-10 Diagnosis Code: [Insert Code]

INSTRUCTIONS:
1. Please perform this imaging as soon as possible.
2. Please fax the formal report to [Fax Number] immediately upon completion.
3. Please provide the patient with a digital copy (CD or Portal Access) of the images.

Sincerely,

[Signature]
[Printed Name of Ordering Physician]
[NPI Number]