diagnostichealth 1025 Berkshire Blvd. Suite 500 • Wyomissing, PA.19610 • Phone: 610-478-8797

Prescription Rx

Fax to: 610-478-8859

(Please print legibly)

Appointment Date: ______________________ **Time:** __________

Patient Name: ______________________ **DOB:** __________

Signs/Symptoms/Chief Complaint: (Diagnosis per AMA guidelines) ______________________

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❑ **MRI**

SPECIFY: ❑ Without Contrast ❑ Without and With Contrast (if needed)

❑ **CT**

SPECIFY: ❑ Without Contrast ❑ Without and With Contrast (if needed)

❑ **X-RAY**

SPECIFY: ______________________

❑ **ULTRASOUND**

SPECIFY: ______________________

❑ **MAMMOGRAM**

SPECIFY: ❑ Screening ❑ Diagnostic ❑ Additional Views ❑ Other

❑ **DEXA SCAN – Bone Densitometry**

If pertinent test parameters (e.g., type, number of views, use of contrast...) are not specified, then follow factory protocol.

Physicians Name: ______________________

Address: ______________________

Physician Signature: ______________________

❑ **CALL WITH RESULTS** ❑ **FAX RESULTS** ❑ **RELEASE FILMS TO PATIENT**