



PATIENT INFO FOR TRANSCRIPTION

PATIENT NAME _____

ACCOUNT NUMBER _____ **DOB** _____

EXAM _____ **W/WO CONTRAST**

DOS _____

ORDERING PHYSICIAN _____ **M.D./D.O.**

_____ **PA/FNP**

PHONE _____ **FAX** _____

HISTORY _____

PRIOR STUDY INFORMATION

ANY PRIOR IMAGING STUDIES ON THIS *EXACT BODY PART*? YES NO

IF, YES WHAT KIND OF STUDY? MRI CT X-RAY US

WHEN? _____ WHERE? _____

ANY PRIOR SURGERY/PROCEDURES ON THIS BODY PART? YES NO

WHAT? _____ WHERE? _____

HISTORY OF CANCER? YES NO

IF YES, TYPE _____ TREATMENT _____