Beth Israel Lahey Health
New England Baptist Hospital

DEPARTMENT OF RADIOLOGY
REQUEST FOR DIAGNOSTIC IMAGES

PLEASE FAX TO (617) 754-6463
TEL: 617-754-5289
NEBHRADIOLOGY@NEBH.ORG

Patient Name_____ Date _____

Date of Birth _____ MED REC#_____

Exam(s) Requested _____

Date of Exam(s) _____

☐ I WILL PICK UP MY IMAGES AND REPORT** (IF AVAILABLE) *(MUST SHOW PHOTO I.D.)*

- IMAGE SERVICE CENTER HOURS:
  - MONDAY – FRIDAY 8:30A-4P
- IMAGES MAY BE PICKED UP AT THE MAIN RADIOLOGY RECEPTION DESK LOCATED IN THE CONVERSE BUILDING ON THE 2ND FLOOR
- PLEASE GIVE 24 HOUR NOTICE WHENEVER POSSIBLE

☐ I AM SENDING A DESIGNEE TO PICK UP MY IMAGES AND REPORT** (IF AVAILABLE)

DESIGNEE NAME _____

***DESIGNEE MUST SHOW PHOTO I.D.*

☐ PLEASE SEND MY IMAGES AND REPORT** (IF AVAILABLE) TO ME/PHYSICIAN:

_____
(ADDRESS LINE 1)

_____
(ADDRESS LINE 2)

_____
(CITY) (STATE) (ZIP CODE)

_____ DATE __/__/__ | TIME __:__ AM/PM
PATIENT/DESIGNEE SIGNATURE

DOL**ALL REPORTS ARE BURNED ONTO THE IMAGE CD AND WILL NOT BE PRINTED AS A SHEET OF PAPER UNLESS SPECIFICALLY REQUESTED. REPORTS ARE TYPICALLY AVAILABLE WITHIN 24-48 HOURS AFTER IMAGING.

There is a $20.00 fee for each CD payable at:

https://www.nebh.org/billpay

FOR OFFICE USE ONLY:

Prepared Images _____(staff initials) **Date Prepared_____**

Photo I.D. checked at pick-up_____(staff initials)