

Hartford ☐

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CONNECTICUT VALLEY RADIOLOGY, PC

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Diagnostic Radiology
Fluoroscopy

QCT Bone Densitometry
Dexa Bone Densitometry

ACR Certified Digital Mammography
ACR Certified Ultrasound

ACR Certified CT Scanning
ACR Certified MRI (Open and Hi Field)

EXAMINATION REQUEST FORM

Patient Name: _____ Patient Date of Birth: ____ / ____ / ____

Exam Requested: _____ Appointment Date and Time: _____

Pertinent Clinical Information: _____

Insurance: _____ Preauthorization Number (If required by Insurance): _____

If having a contrast (Dye) exam for CT Scan, MRI or IVP, is Patient:

Allergic to IV Contrast (Dye)? Yes _____ No _____

- 1. Diabetic? Yes _____ No _____ Medication _____
- 2. Have Impaired Renal Function? Yes _____ No _____
- 3. Hypertension? Yes _____ No _____
- 4. Over 60 years of age? Yes _____ No _____

★If Yes to any of the Above, Provide the Following: BUN _____ CREATININE _____ GFR _____ Date Drawn _____

Physician Signature: _____

Instructions for exams on reverse side