Radiology

OPEN MRI, SPIRAL CT SCAN
MAMMOGRAM, DEXA SCAN
IMAGING

DIAGNOSTIC XRAY, FLUOROSCOPY
ULTRASOUND, DOPPLER

Month dd, yyyy

Ref Dr Name

Patient Name : **xxxxxxxxx**
Med Record # : **xxxxxxxx**
DOB :
Chart # : **N/A**

CT OF THE ABDOMEN AND PELVIS WITHOUT CONTRAST: mm/dd/yyyy

TECHNIQUE:

FINDINGS:

IMPRESSION:

1. _____.
2. _____.

Thank you for your referral.