



**Green Imaging**

**Fax to:  
866 653 0882**

*If Signed by Physician this will constitute Official Exam Order*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home/Work/Cell Phones: \_\_\_\_\_

Email: \_\_\_\_\_

**Exams Requested:**

\_\_\_\_\_  
\_\_\_\_\_

*If you are not sure if contrast is indicated, do not specify and radiologist will protocol.*

**Clinical Information/Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

**Ordering Physician Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred route to receive report: ( fax / EMR / secure email link )

**Physician Signature:** \_\_\_\_\_

*FAX form to 866-653-0882 and we will schedule the exam with patient.  
Thank you for your referral!*