New Mexico Cancer Center
NEW MEXICO ONCOLOGY HEMATOLOGY CONSULTANTS, LTD.

Health Specialists OF NEW MEXICO

Please fax this form to
505-822-3912

RADIOLOGY IMAGING EXAM REQUEST FORM

PATIENT INFORMATION

Name: _____ Sex: ☐ M ☐ F

Phone Number: _____ DOB: _____

Address: _____

Note: PLEASE FAX MOST RECENT CLINIC NOTES, DEMOGRAPHICS, EXAM PRIOR AUTHORIZATION

Exam Required: _____
PLEASE BE SPECIFIC

DIAGNOSIS CODE: _____

Exact Region of Interest: _____

CLINICAL INFORMATION

Tentative Diagnosis / Reason for Exam: _____

Relevant Previous Imaging Studies: ☐ X-Ray ☐ PET ☐ CT ☐ MRI

Location of previous studies: _____

FOR CT PATIENTS ONLY

	Yes	No
Previous allergy to IV contrast or iodine	☐	☐
Patient has history of kidney disease or bladder cancer	☐	☐
Patient is diabetic	☐	☐
On Glucophage (Metformin)	☐	☐

FOR MRI PATIENTS ONLY

	Mark if it applies:
Claustrophobia**	☐
Cochlear implant	☐
Brain Aneurysm Clip	☐
Neuro Stimulator	☐
Pacemaker	☐

Any history of kidney disease, a recent (within 1 week) Creatinine (GFR) level will be needed.

Creatinine (GFR): _____ Date: _____

GFR NEEDED FOR ALL CT EXAMS WITH CONTRAST

Referring Physician's Signature or Stamp:

Physician's Signature: _____

Physician's Name: _____

Physician's Phone: _____

If the patient is **Claustrophobic and needs medication, the referring physician needs to order them

Revised 10/2026