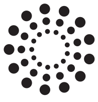
EXAM ORDER FORM



CHEYENNE RADIOLOGY

Date: _______/_______/_______

Patient Name: ____

Date of Birth: _______/_______/_______

Appointment Date & Time: _______/_______/_______ _____:_______ ☐ AM ☐ PM

Study Requested: __________________________________

Symptoms: __________________________________

Physician Signature: ____________________________ Printed: ____________________________

Routine: ______________ Phone Report: __________________

SERVICES AVAILABLE:

- Radiography & Fluoroscopy
- C-Arm Procedures
- Ultrasound
- Digital Mammography
- Osteoporosis Screening
- Nuclear Medicine
- PET/CT Scans
- CT/CTA
- MRI/MRA

Thank you for choosing Cheyenne Radiology. If you have any questions or concerns, feel free to contact our office at 307-634-7711.