MOUNT SINAI MEDICAL CENTER
DEPARTMENT OF RADIOLOGY

Down Time Form

One form per procedure

Please provide Fax Number to for you to receive REPORT results: 646-537-8912

Forms MUST be faxed to 212-241-8759 or hand delivered

Date_____/_____/_____

Patient Name_____ MR#_____Admit #_____

Patient Location_____ Pt. Type (circle one): I ER

Travels by (circle one): Chair Stretcher Walk Bedside

Ordering Doctor/Dictation code_____PCN:_____

Signature of ordering physician_____

Exam Ordered (Required)	Exam #	Ordered for Date	Ordered for time	Priority
Reason for Exam (Required)				

OFFICE USE ONLY			
Tracking times	Time	Initials	
Send for Patient (tech or dispatcher)			
Transporter dispatched (transporter)			
Enter Department (transporter)			
Begin Procedure (tech)			
End Procedure (tech)			
Radiologist	Date Read	Time Read	Comments

DOB:_____/_____/_____ **SS#**_____-_____-_____

Entered into Centricity RIS? (Y / N) Name of person placing order in Centricity RIS _____