Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

Weill Cornell Medicine
Radiology

Imaging Performed at Outside Practices

Fill out entirely or request will be rejected

Today's Date_____ Date of Study_____

Date needed by _____ Type of Study_____

Patient Name_____

DOB_____ NYPH/WC MRN_____

Diagnosis/ Relevant History:_____

_____

Clinical Information Required for Re-interpretation :

_____

_____

Original Imaging Facility_____

Requesting Physician_____
(Full Name)

Signature_____

Submitted by_____

Requester's Direct Phone #_____

☐ Disc to be discarded after upload

Please Choose One:

☐ **Archive-** exam to be stored in our system for future reference. The submitted exam will be used as a **comparison**.

☐ **Re-interpretation-** formal read of the outside study for a second opinon or consult.

Please note: all re-intepretation requests require a copy of the original report

Please indicate necessity below:
(check all that apply)

☐ There is a question of a particular finding.

☐ There is a need for a higher level of specialized care.

☐ There is a clinical question in correlating the medical and imaging history.

For Office Use ONLY

PRINT ONLY

Received by_____

Nominated by_____

Accession Number(s)_____