

UTHealth Science Center of Houston

Diagnostic and Interventional
Imaging 6431 Fannin Street, MSB
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Physician Second Read Order Form

Patient Information

_____	Date
Name (Last, first, middle initial)	Date of Birth
Street address, City, ST, ZIP Code	Social Security # or Patient ID
Primary phone number Other phone number	Email address
Insurance Name	Insurance ID
Insurance Group Number:	_____

Type of Request – Referral for Second interpretation on outside imaging study

Specify exam for second opinion	Date of original exam
Clinical indication for original study	Diagnosis code
Indication for second Opinion interpretation	_____

Physician Signature

Date

Physician name:

Street address, City, ST, ZIP Code: _____

Phone #: _____ Fax #: _____

Images sent via:

- CD to be uploaded Image gateway UT PACS / MH PACS

Attach additional documentation as applicable. _____

For Administrative Use Only:

_____	Date received
Action taken	_____

Once the order is scanned into the EMR, kindly destroy confidential information appropriately.