



CULLMAN
REGIONAL

REQUEST FOR RADIOLOGY REPORT AND/OR FILM

CULLMAN REGIONAL RADIOLOGY DEPARTMENT

1912 Alabama Hwy 157

Cullman AL 35058

Phone: (256) 737-2180

Fax: (256) 737-2877

Date / Time: _____
Physician Office / Staff Requesting: _____
Office Phone: _____ Office Fax: _____

INFORMATION NEEDED:

Patient Name: _____ DOB: ____/____/____

Test(s) needed: _____ DOS: ____/____/____

Information Requested

*Radiology Report _____ *Request to PUSH FILM: _____

Patient Name: _____ DOB: ____/____/____

Test(s) needed: _____ DOS: ____/____/____

Information Requested

*Radiology Report _____ *Request to PUSH FILM: _____

Patient Name: _____ DOB: ____/____/____

Test(s) needed: _____ DOS: ____/____/____

Information Requested

*Radiology Report _____ *Request to PUSH FILM: _____

Patient Name: _____ DOB: ____/____/____

Test(s) needed: _____ DOS: ____/____/____

Information Requested

*Radiology Report _____ *Request to PUSH FILM: _____

Please allow up to 24 hours to receive images.

If immediate need, please call (256) 737-2180.

Signature of person requesting: _____