Touchstone
MEDICAL IMAGING

CT Non-Contrast Form

(Colorado & Omaha)

PATIENT NAME:____**PATIENT ID#:**_______________**DOB:**________

LAST NAME FIRST NAME MIDDLE

EXAM:____**DATE OF SERVICE:**_________________________

What are your symptoms?____

____

____

How long have you had these symptoms?____

____

____

Have you had surgery to this area before?_________________**YES**_________________**NO**

If yes, explain:____

____

____

Are you pregnant?_________________**YES**_________________**NO**

I have answered the questions above to the best of my knowledge and understand the information presented is correct.

Patient/Parent/Legal Guardian:____**Date:**_____________________

Technologist:____**Date:**_____________________