



**New Referring Physician Information and Preferences**

**Please complete and FAX to: 310-432-8995**

Physician Name: Last \_\_\_\_\_ First \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Telephone (Office) \_\_\_\_\_ Telephone (Mobile) \_\_\_\_\_

FAX \_\_\_\_\_ Email \_\_\_\_\_

**How would you like reports/results to be sent to you:**

|                         | <u>FAX</u> | <u>Email</u> | <u>Text/SMS</u> | <u>Call Cell Phone</u> |
|-------------------------|------------|--------------|-----------------|------------------------|
| Routine Imaging Studies | _____      | _____        | _____           | _____                  |
| STAT studies            | _____      | _____        | _____           | _____                  |

**Would you like web bases access to our PACS system to view images?** Yes \_\_\_\_\_ No \_\_\_\_\_

\*\* If you selected "Yes" for PACS access, a member of our staff will contact you with your user name and password after receiving this form.