## Outside Images to be Digitized or Imported

Date: Time:	Other Instructions:		
Patient Name:			
Patient UW#:			
☐ CD Images to Import	Images From:		
□ Films to Digitize # of Films:			
	Address:		
□ Hold at file room for pickup or			
☐ Return films/CD to:	☐ Plain Films ☐ CT☐ PET ☐ Angio☐ Arthroscopy	□ MRI □ U/S	□ NM □ Fluoro
	Fileroom use only:		
Requested by:			
Phone Number:	Time Completed:		