Ultrasound Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting radiologist and any other practitioner that you specify.

Name: ______________________________ Date of Birth: ____________

Address: ______________________________

Phone: ______________ Email Address: ______________________________

How do you want to receive your results? ☐ Mail ☐ Email ☐ Use information above.

____

Do you want a copy of your results sent to your physician or other healthcare provider (not required)?

1. Name: ______________________________ Fax: ____________

   Address: ______________________________

2. Name: ______________________________ Fax: ____________

   Address: ______________________________

I authorize DITI Imaging to release this questionnaire and the images from my scan to **Rapid Radiology** for interpretation.

Signature: ______________________________ Date: ____________