Children's of Alabama

Pediatric Imaging Test Request for RESEARCH Study

Date _____

Patient Name_____

MR# (if applicable) _____

DOB _____

Study Name _____

IRB# _____

For questions, please contact _____
(Research coordinator name and phone number)

Please add detailed instructions on the tests ordered, complete test name, no initials:

Tests/Complete Name

1. CT_____
2. MRI _____
3. Diagnostic _____
4. Other _____

Physician's Signature_____

Please complete form and email to terri.estes@chsys.org (or fax to 558-2070) and Becky Burgess of Pediatric Radiology Associates, PC beckyburgess@brg-spb.com.