OUTPATIENT DIAGNOSTIC CENTER
PATIENT PROCESSING FORM

Your Hospital's Logo Here

PATIENT NAME:			DATE:		ARRIVAL TIME:

SERVICE	EXAM ORDERED (√)	EXAM TYPE	EXAM TIME Start	End	TECHNICIAN (Initials)
RADIOLOGY					
LABORATORY					
CARDIOLOGY					
P F T					
RESPIRATORY					

☐ Special Needs Patient   COMMENTS: _____

Please place this form in the "Outpatient Questionnaire" box in the general waiting area, or give it to the receptionist at the Front Desk.   THANK YOU