	DATE/TIME **REQUIRED**	PATIENT LAST NAME	TODAYS DATE/TIME

PRINT CLEAR

IMPORTANT: Please set a due date and time based on your needs, such as patient appointment, surgery date/time, etc. If you don't specify a due date, your request will be processed after all other dated or prior requests have been completed.

Oregon Health & Science University
Hospitals and Clinics
OHSU Image Library
3181 SW Sam Jackson Park Rd,
Mail Code: UHS 5 Portland, OR 97239-3098
(503) 494-8631, Fax (503) 494-5020
Business hours: Monday-Friday, 6:30 AM - 6:00 PM

ACCOUNT NO:	
MED. REC. NO:	
NAME:	
BIRTHDATE:	

OHSU Image Library – Digitization Request Form

Requester Information	
Name:	**Pager:**
Department:	**Phone:**
Attending Physician:	

Please BE SPECIFIC about exams to digitize. Only selected films/CDs will be imported into PACS.

Films (HC = hardcopies) / CDs				
CD	**FILM**	**Film Type/ Exam**	**Study Date**	**Facility Name/ Location**
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

CDs and film copies (not originals) will be discarded unless otherwise specified.

After Digitization
☐ **Discard**
☐ **Return To Original Facility (Films only)**
☐ **Return To Requester / Mail Code(Required):**
☐ **Return To Patient:**
(Patient Address required)
☐ **Other:**