



Radiology Scheduling Request

Please fill out the form, hit Submit, and send an encrypted email to dha.belvoir.fbch.list.radiology-msa@mail.mil. We will contact you within three business days to confirm scheduling of your appointment.

Date: _____

Patient's Name (Last, First): _____

Patient's DoD ID Number (10-digit # on ID CARD): _____

Patient's Date of Birth: _____

Patient's Email Address: _____

Patient's Primary Phone Number: _____

Patient's Secondary Phone Number: _____

Sponsor's Last Four SSN: _____

Preferred Time to Contact You: _____

Preferred Study Day of the Week 1: _____

Preferred Time of Day 1: _____

Preferred Study Day of the Week 2: _____

Preferred Time of Day 2: _____

Preferred Study Day of the Week 3: _____

Preferred Time of Day 3: _____

Type of Study: _____

Ordering Provider: _____

Comments:

Privacy Act Statement: In accordance with the Privacy Act of 1974 (Public Law 93-579), this informs you of this document's purpose and how it will be used.

Authority: 10 U.S.C 136; 10 U.S.C 1074; DoD Directives 1404. 10, 5101.1, 5136.01, and 6490.02E; and DoD Instruction 6025.19.

Purpose: To obtain information in order to schedule appointments through the Military Treatment Facility at the beneficiary's request.

Disclosure: Voluntary