St. Claire Regional Medical Center
Diagnostic Imaging Department
222 Medical Circle
Morehead, Kentucky 40351
Office 606.783.6761
Fax 606.783.6935

Diagnostic Imaging Preliminary Interpretation Form

Date: _____

Patient's Name: _____ Patient's DOB: _____

ID Number: _____ Medical Record Number: _____

Exam: _____ Accession # (if available**)** _____

TO BE COMPLETED BY RADIOLOGIST

Impression: _____

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Radiologist's Signature: _____ **Date:** _____

Distribution: White – Patient's chart; Yellow – EDM & PACS