DERRY IMAGING

CD/REPORT REQUEST FORM

Patient Name: _____

Date of Request: _____

Patient Date of Birth: _____

Exam Type(s): _____

Date of Exam(s): _____

Pick up location: Please choose one

Bedford Concord Derry Dover Londonderry Raymond Windham

Mail (please provide address) _____

Who will be picking up? _____

Please note:

- If we are mailing to anyone other than the patient, please fill out a Medical Release form.
- Requested CD's will be ready for **pick up in 24-48 hrs**.
- Requests for **mammography** imaging may take up to **72 hrs**.