Winchester District Memorial Hospital

CD REQUEST

Fax to: Diagnostic Imaging Department at 613-774-5385

Date: _____

Requestor: _____

Please burn CD on the following patient:

Patient Name: _____ WDMH MRN: _____

Date of Birth: Day: Month: Year: _____

Exams requested: _____

_____

Destination: _____

_____

❑ Please send to above destination

❑ Patient will pick up **OR** ❑ Designate will pick up : _____
(Print Name)

❑ Report attached

FOR WDMH STAFF USE AT TIME OF PICK UP

The above mentioned examinations are for medical or legal use only. Once in my possession, I am responsible for proper storage and/or destruction of the CD when no longer needed. Any CD's returned to WDMH will be properly destroyed.

WDMH is not responsible for lost, stolen or damaged CDs.

Patient/Designate Name (Please print): _____

Patient/Designate Signature: _____ Date: _____

Burned by: _____

Date and Time: _____