SOUTHWEST DIAGNOSTIC CENTER FOR MOLECULAR IMAGING™

ELECTRONIC REPORT DELIVERY

Physician(s): _____

Group Name: _____

Address: _____
City State Zip

Phone: _____

1. What EMR are you using? _____
   - What version? _____

2. Do you have direct messaging capabilities? ❑ Yes ❑No
   - If Yes, what is the address: _____

3. IT Person Contact:
   - Name: _____
   - Phone: _____
   - Email: _____

4. EMR Contact:
   - Name: _____
   - Phone: _____
   - Email: _____

Please fax completed form to 214-345-6519

or email dlswdicsupportsystems@texashealth.org

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