SOUTHWEST™ DIAGNOSTIC
IMAGING CENTER

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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