



VIRTUAL RADWARE
A SHIELDS HEALTH CARE GROUP COMPANY

FILM DIGITIZING SUBMISSION FORM

STUDY INFO (Submit one form per Study)

Patient Name: _____

Patient ID: _____

Patients DOB: _____

Date of Service: _____

Modality Type: _____

Scan Type: _____

of Sheets: _____

Client Name

Date of Submission

Check One: Same Day

48 Hrs

72 Hrs

Submitted By (Print Name):

Date

Submitted By (Signature):

Date

OFFICE USE ONLY

Completed By:

Completed

On:

Notes: