Lowell General Hospital

Complete connected care℠

Request for Images

Date: ______________________

Requested by: ____

Patient's Name: ____

Date of Birth: _________________________

Type of Exam(s): ____

Date of Exam: ____

Name of Physician you are bringing CD to: ____

Campus Pick up location:

☐ Lowell General Hospital
Main Campus
295 Varnum Ave.
Lowell, MA 01854

☐ Lowell General Hospital
Saints Campus
1 Hospital Drive
Lowell, MA 01852

Contact Phone Number: ____

(To confirm images are ready for pick up.)

Be sure to bring a Photo ID for verification.