

Date: _____

Patient Name: _____ DOB: _____ Phone: _____

Patient Insurance: _____ Policy #: _____ Group#: _____

Prior Authorization # (if req'd): _____

Clinical Indication/Diagnosis _____

Referring Physician's Name _____

Referring Physician's Signature _____ Date: _____

X-ray

HEAD & NECK

- Mandible
- Facial Bones
- Nasal Bones
- Orbits
- Paranasal Sinuses
- Skull
- Neck (soft tissue)

SPINE & PELVIS

- C-Spine Add Flex & Exten
- T-Spine Scoliosis Study
- L-Spine Add Flex & Exten
- Pelvis Sacrum & Coccyx
- S I Joints

RIBS

- Unilateral L R
- Unilateral w/chest L R
- Bilateral
- Bilateral w/chest (PA & LAT)
- Sternum

ABDOMEN

- KUB
- Two Views

CHEST

- One View (PA)
- Two Views (PA & LAT)
- Two Views w/Lordotic
- Specify _____

UPPER EXTREMITIES

- Clavicle L R
- Scapula L R
- Shoulder L R
- A/C Joints
- S/C Joints
- Humerus L R
- Elbow L R
- Forearm L R
- Wrist L R
- Hand L R
- Finger(s) L R

LOWER EXTREMITIES

- Hips Unilateral L R
- Hips Bilateral
- Pelvis L R
- Femur L R
- Knee L R
- Knees, both standing, AP
- Tibia & Fibula L R
- Ankle L R
- Foot L R
- Calcaneus L R
- Toes(s) L R
- Other _____

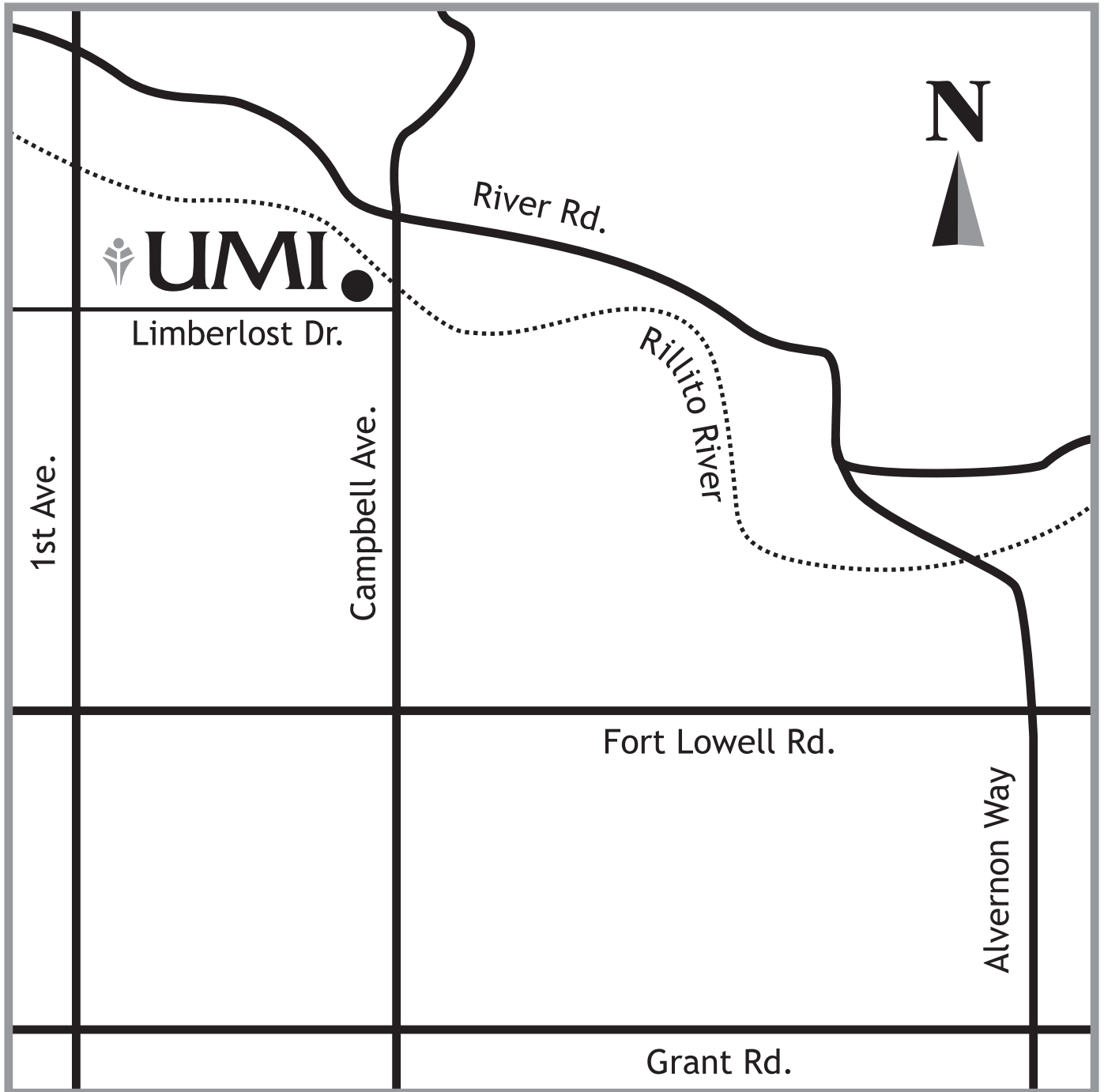
Ultrasound

Special Instructions

- Abdomen
- Pelvis Female Pelvis w/Transvag (if indicated)
- Testicular Renal
- Venous Doppler Aorta
- Carotid Doppler Thyroid
- Other (specify) _____

The information contained in the FAX is CONFIDENTIAL and/or legally privileged, intended only for the use of the above mentioned facilities. If you received this in error, please call 520-425-8900

Map



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