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RADIOLOGIC CONSULTATION REQUEST

Referring Doctor:_____Clinic Name:_____

Address:_____

City:_____ State:_____ Zip: _____

Phone:_____ Email:_____

Fax:_____

Patient Information

Patient Name (Please write legibly): _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Date of Study:_____

Pertinent Clinical Information including signs/symptoms AND working diagnosis

_____

_____

_____

Health History

Surgery:_____Date:_____

Trauma:_____Date:_____

Malignancy:_____Date:_____

Areas of Special Concern:_____

_____

Name of the facility where the images were taken if not taken in your office:_____

_____

Views Submitted (Please mark all that apply)

- ☐ Ankle, 3 Views
- ☐ Cervical, 2 or 3 Views
- ☐ Cervical, 4 or 5 Views
- ☐ Davis Series, 7 Views
- ☐ Chest, 2 Views
- ☐ Comparison View
- ☐ CT or MRI
- ☐ Elbow, 4 Views
- ☐ Foot, 3 Views
- ☐ Full Spine, 6 or 7 Views
- ☐ Hand, 3 Views
- ☐ Hip, 2 Views
- ☐ Knee, 2 Views
- ☐ Knee, 3 or 4 Views
- ☐ Lumbar, 2 or 3 Views
- ☐ Lumbar, 4 or 5 Views
- ☐ Shoulder, 3 Views
- ☐ Thoracic, 2 or 3 Views
- ☐ Wrist, 4 Views
- ☐ Other _____

Any Additional Comments:

_____

_____

_____