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PHYSICIAN'S EXAM REQUEST FORM

PATIENT NAME _____ DOB _____ SS# _____
 ADDRESS _____ PHONE _____ ALT# _____
 CITY, STATE _____ ZIP _____
 DIAGNOSIS _____ ICD 9 _____
 HISTORY _____
 _ SURGERY _____
 _ CANCER _ PACEMAKER _ IMPLANTS _____

X-RAY

<input type="checkbox"/> Chest 1 View-AP	<input type="checkbox"/> L-Spine-AP/LAT	<input type="checkbox"/> Knee L R	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chest 2 ViewsPA/LAT	<input type="checkbox"/> L-Spine 5 Views	<input type="checkbox"/> Shoulder L R	
<input type="checkbox"/> Abdomen-KUB	<input type="checkbox"/> C-Spine 3 Views	<input type="checkbox"/> Ankle L R	
<input type="checkbox"/> Abdomen -Flat/Erect	<input type="checkbox"/> C-Spine 5 Views	<input type="checkbox"/> Foot L R	
<input type="checkbox"/> KUB + OBLIQ L R	<input type="checkbox"/> Pelvis-AP	<input type="checkbox"/> Elbow L R	
<input type="checkbox"/> Ribs L R	<input type="checkbox"/> Pelvis-AP+Frogleg	<input type="checkbox"/> Wrist L R	
<input type="checkbox"/> Scapula L R	<input type="checkbox"/> Hip L R	<input type="checkbox"/> Femur L R	
		<input type="checkbox"/> Tib/Fib L R	

MRI _ With Contrast _ Without Contrast

SUPINE			POSITIONAL
<input type="checkbox"/> Brain	<input type="checkbox"/> L-Spine	<input type="checkbox"/> Knee L R	<input type="checkbox"/> L-Spine
<input type="checkbox"/> Brain W/DWI	<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Shoulder L R	<input type="checkbox"/> C-Spine
<input type="checkbox"/> IC MRA	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Ankle/midfoot L R	<input type="checkbox"/> <i>Weight Bearing</i>
<input type="checkbox"/> IAC's	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Midfoot/forefoot L R	<input type="checkbox"/> <i>+ Flex/Ext</i>
<input type="checkbox"/> Orbits	<input type="checkbox"/> Spinal Survey	<input type="checkbox"/> Wrist L R	or
<input type="checkbox"/> Head/Neck/Face	<input type="checkbox"/> Hips (bilat)	<input type="checkbox"/> Hand L R	<input type="checkbox"/> <i>Position of pain</i>
	<input type="checkbox"/> Pelvis (Female)	<input type="checkbox"/> Abdomen L R	<input type="checkbox"/> <i>Position of pain</i>
		<input type="checkbox"/> Other _____	KINEMATIC
			<input type="checkbox"/> <i>patellar motion (knee)</i>

CT _ With IV Contrast _ Without IV Contrast

<input type="checkbox"/> Abdomen only	<input type="checkbox"/> Brain/Skull	<input type="checkbox"/> L-Spine
<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Sinus Limited	<input type="checkbox"/> C-Spine
<input type="checkbox"/> Pelvis only-soft tissue	<input type="checkbox"/> Sinus Complete	<input type="checkbox"/> Bone/Joint _____
<input type="checkbox"/> Abdomen-Renal stone	<input type="checkbox"/> Temp Bone/IAC's	<input type="checkbox"/> Reconstruction
<input type="checkbox"/> Chest-Routine	<input type="checkbox"/> Neck(Soft Tissue)	<input type="checkbox"/> SAGG
<input type="checkbox"/> Lung-High resolution	<input type="checkbox"/> CTA-Carotids	<input type="checkbox"/> COR
<input type="checkbox"/> CTA-upper ext	<input type="checkbox"/> Facial bones	<input type="checkbox"/> 3-D
<input type="checkbox"/> CTA-lower ext	<input type="checkbox"/> Orbits	<input type="checkbox"/> Other _____

U/S

Abdomen	Pelvis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Other _____
<input type="checkbox"/> complete	<input type="checkbox"/> <i>transabdominal</i>	<input type="checkbox"/> Carotid Doppler	
<input type="checkbox"/> <i>liver/biliary only</i>	<input type="checkbox"/> <i>+ endovaginal</i>	<input type="checkbox"/> Venous Doppler UE LE L R	
<input type="checkbox"/> <i>renal only</i>	<input type="checkbox"/> OB	<input type="checkbox"/> Arterial Doppler UE LE L R	
<input type="checkbox"/> <i>gall bladder only</i>	<input type="checkbox"/> <i>scrotum/testes</i>	<input type="checkbox"/> Aorta	
<input type="checkbox"/> <i>liver/spleen</i>			

SPECIAL INSTRUCTIONS _____

RETURN APPOINTMENT _____

PHYSICIAN'S

SIGNATURE _____ **DATE** _____