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salem radiology

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NAME: _____ DOB: _____

CLINICAL HISTORY – please include signs and symptoms _____

REF PHYSICIAN: _____ PHONE: _____ FAX: _____

Wet Read? _____

Exam requested but not listed below: _____

Please Circle Exam Requested

These exams may be performed on a Walk-in Basis:										
X-Ray					Ultrasound					
Abdomen - KUB					Lower Leg	R	L	Bil	Abdominal	
Abdomen - Flat & Uppt					Lumbar Spine				Carotid	
AC Joints					Mandible				Extremity - Non-Vascular	
Ankle	R	L	Bil		Nasal Bones				Leg for DVT	R L Bil
Bone Age					Orbits				Pelvic	
Cervical Spine					Pelvis				Renal/Bladder	
Chest					Ribs	R	L	Bil	Aorta	
Child - Upper Extr.	R	L	Bil		Sacrum & Coccyx				Thyroid	
Child - Lower Extr.	R	L	Bil		Scapula	R	L	Bil	Other	
Clavicle	R	L	Bil		Scoliosis Series					
Elbow	R	L	Bil		Shoulder	R	L	Bil		
Facial Bones					SI Joints					
Femur	R	L	Bil		Sinuses				Notes: _____ _____ _____ _____ _____ _____ _____	
Foot	R	L	Bil		Skull					
Forearm	R	L	Bil		Soft Tissue Lat Neck					
Hand	R	L	Bil		Sternum					
Heel	R	L	Bil		Thoracic Spine					
Hip	R	L	Bil		TMJs					
Humerus	R	L	Bil		Water's View					
Knee	R	L	Bil		Wrist	R	L	Bil		
Specific Views Requested:										
(e.g. AP & Lat only)										