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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:				These exams need to be scheduled:								
X-Ray				Breast Imaging				OB Ultrasound				
Abdomen - KUB				Lower Leg	R	L	Bil	Mammogram - Screening				Less Than 14 Weeks
Abdomen - Flat & Uprt				Lumbar Spine				Mammogram - Diagnostic				Greater than 14 Weeks
AC Joints				Mandible				Mammogram - Unilateral	R	L		Biophysical Profile
Ankle	R	L	Bil	Nasal Bones				Ultrasound	R	L	Bil	Interventional
Bone Age				Orbits				Biopsy				PICC Line Placement
Cervical Spine				Pelvis				Cyst Aspiration				Thyroid Biopsy
Chest				Ribs	R	L	Bil	Bone Densitometry				Punc. Aspiration Abcess, Cyst
Child - Upper Extr.	R	L	Bil	Sacrum & Coccyx				DEXA Scan:				Thoracentesis
Child - Lower Extr.	R	L	Bil	Scapula	R	L	Bil	Ultrasound				Paracentesis
Clavicle	R	L	Bil	Scoliosis Series				Abdominal				Renal Cyst Aspiration
Elbow	R	L	Bil	Shoulder	R	L	Bil	Carotid				Biopsy:
Facial Bones				SI Joints				Extremity - Non-Vascular				_____
Femur	R	L	Bil	Sinuses				Leg for DVT	R	L	Bil	Other: _____
Foot	R	L	Bil	Skull				Pelvic				Fluoroscopy
Forearm	R	L	Bil	Soft Tissue Lat Neck				Renal				Barium Enema
Hand	R	L	Bil	Sternum				Retroperitoneal				Barium Enema w/Air
Heel	R	L	Bil	Thoracic Spine				Testicular				Barium Swallow
Hip	R	L	Bil	TMJs				Thyroid				Small Bowel
Humerus	R	L	Bil	Water's View				Transvaginal				Upper GI
Knee	R	L	Bil	Wrist	R	L	Bil	Visceral				
Specific Views Requested: (e.g. AP & Lat only)												