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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							
Abdomen - KUB				Lower Leg	R	L	Bil
Abdomen - Flat & Uprt				Lumbar Spine			
AC Joints				Mandible			
Ankle	R	L	Bil	Nasal Bones			
Bone Age				Orbits			
Cervical Spine				Pelvis			
Chest				Ribs	R	L	Bil
Child - Upper Extr.	R	L	Bil	Sacrum & Coccyx			
Child - Lower Extr.	R	L	Bil	Scapula	R	L	Bil
Clavicle	R	L	Bil	Scoliosis Series			
Elbow	R	L	Bil	Shoulder	R	L	Bil
Facial Bones				SI Joints			
Femur	R	L	Bil	Sinuses			
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)

These exams need to be scheduled:

Breast Imaging				OB Ultrasound
Mammogram - Screening				Less Than 14 Weeks
Mammogram - Diagnostic				Greater than 14 Weeks
Mammogram - Unilateral	R	L		Biophysical Profile
Ultrasound	R	L	Bil	**Interventional**
Biopsy				PICC Line Placement
Cyst Aspiration				Thyroid Biopsy
Bone Densitometry				Punc. Aspiration Abcess, Cyst
DEXA Scan:				Thoracentesis
Ultrasound				Paracentesis
Abdominal				Renal Cyst Aspiration
Carotid				Biopsy:
Extremity - Non-Vascular				____________
Leg for DVT	R	L	Bil	Other: ____________
Pelvic				**Fluoroscopy**
Renal				Barium Enema
Retroperitoneal				Barium Enema w/Air
Testicular				Barium Swallow
Thyroid				Small Bowel
Transvaginal				Upper GI
Visceral				

REF PHYSICIAN
Print ____________ ____________ Signature ____________