

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Wet Read: \_\_\_\_\_

**REFERRING PHYSICIAN REQUEST FORM**

Physician Signature Date: \_\_\_\_\_

PATIENT MUST HAVE THIS FORM TO RECEIVE EXAM

X-Ray		ICD 10	Diagnosis	Ultrasound		ICD 10	Diagnosis
Abdomen (KUB)				Breast	RT___ LT___		
Abdomen (Flat/Erect)				Carotid Duplex			
AC Joints				Abdomen			
Ankle	RT___ LT___			OB			
C-Spine AP/LAT				Biophysical Profile			
C-Spine Series				Pelvis			
C-Spine with FLEX/EXT				Renal / Aorta			
Chest (1 View)				Scrotum			
Chest (2 Views)				Thyroid			
Clavicle	RT___ LT___			Renal Artery Doppler			
Elbow	RT___ LT___			Venous Duplex ARM			
Facial Bones				Venous Duplex LEG	RT___ LT___		
Femur	RT___ LT___			Pelvis: Transvaginal	RT___ LT___		
Fingers	RT___ LT___						
Foot	RT___ LT___						
Forearm	RT___ LT___						
Hand	RT___ LT___						
Heel (Calcaneous)	RT___ LT___						
Hip	RT___ LT___						
Humerus	RT___ LT___						
Knee	RT___ LT___						
L-Spine AP/LAT							
L-Spine Series							
L-Spine with FLEX/EXT							
Mandible							
Nasal Bones							
Neck, Soft Tissue							
Orbits / Foreign Body							
Pelvis AP							
Ribs	RT___ LT___						
Sacroiliac Joint							
Sacrum/Coccyx							
Scapula	RT___ LT___						
Scoliosis Series							
Shoulder	RT___ LT___						
Sinus Series							
Skull Series							
Sternum							
Thoracic Spine							
Tibia-Fibula	RT___ LT___						
Toes	RT___ LT___						
Wrist	RT___ LT___						