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APPOINTMENT

DATE:

TIME:

If you must reschedule or cancel your appointment, please give at least 24 hours notice.

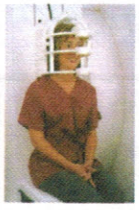
Patient Name: _____ Date of Referral _____
First MI Last

Chief Complaint(s) and Brief History: _____

_____

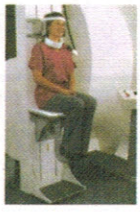
_____

Diagnosis _____ Patient Phone _____



Brain
- ☐ Routine
- ☐ TMJ
- ☐ Posteria Fossa
- ☐ Sinuses
- ☐ IAC's
- ☐ Pituitary
- ☐ Orbits

MRA
- ☐ Circle of Willis
- ☐ Carotid Arteries



Spine
- ☐ Cervical specify below
- ☐ Thoracic
- ☐ Lumbosacral specify below

Misc.

- ☐ Abdomen
- ☐ Pelvis
- ☐ Prostate
- ☐ Other

_____

_____

_____

Lower Extremity

☐ Hip	☐ L	☐ R
☐ Knee	☐ L	☐ R
☐ Ankle	☐ L	☐ R
☐ Foot	☐ L	☐ R

Upper Extremity

☐ Shoulder	☐ L	☐ R
☐ Elbow	☐ L	☐ R
☐ Wrist	☐ L	☐ R
☐ Hand	☐ L	☐ R

LUMBOSACRAL

☐ Neutral Upright

☐ Flexion Upright

CERVICAL

☐ Neutral Upright

☐ Flexion Upright

☐ Extension Upright

☐ Extension Upright

Perform Recumbent Scan for Comparison? ☐ Yes ☐ No **WITH CONTRAST?** ☐ Yes ☐ No

Special Instructions or Comments: _____

_____

Authorized Signature _____

Referring Physician's Name _____ **Phone** _____ **Fax** _____

Patient Scan results Report - (Please ✓)

Written Report ☐ Fax or ☐ Email ☐ Film Requested ☐ CD ROM results