



Use the QR code to request an appointment or find your closest Capital Radiology location

CHIROPRACTIC IMAGING REQUEST

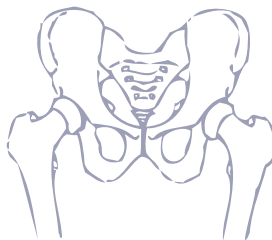
PATIENT DETAILS:

Name: _____ DOB: _____

Address: _____

Telephone: _____ Medicare No: _____

CLINICAL NOTES: (Please mark area of clinical concern)



For female patients, is there any chance the patient may be pregnant? Yes No

REFERRER DETAILS:

Signature: _____

Date: _____

IMAGING MODALITY REQUESTED

X-Ray CT MRI US

VIEWS REQUESTED

- | | | |
|-------------------|---------------------|--------------------------|
| CERVICAL SPINE: | AP OM | <input type="checkbox"/> |
| | AP LC | <input type="checkbox"/> |
| | Neutral Lateral | <input type="checkbox"/> |
| THORACIC SPINE: | AP | <input type="checkbox"/> |
| | Lateral | <input type="checkbox"/> |
| LUMBAR SPINE: | AP | <input type="checkbox"/> |
| | Lateral | <input type="checkbox"/> |
| | AP Lumbo-Pelvic | <input type="checkbox"/> |
| | SIJs | <input type="checkbox"/> |
| TWO REGION SPINE: | Cervical - Thoracic | <input type="checkbox"/> |
| | Thoracic - Lumbar | <input type="checkbox"/> |
| HIPS: | Left | <input type="checkbox"/> |
| | Right | <input type="checkbox"/> |

Additional Views:

- | | | |
|--------------------|----------|--------------------------|
| Obliques: | Cervical | <input type="checkbox"/> |
| | Lumbar | <input type="checkbox"/> |
| Flexion/Extension: | Cervical | <input type="checkbox"/> |
| | Lumbar | <input type="checkbox"/> |

Other: (Please specify)

REPORT:

- | | |
|--|---|
| <input type="checkbox"/> Routine | <input type="checkbox"/> Telephone report |
| <input type="checkbox"/> Return with patient | <input type="checkbox"/> Facsimile report |
| <input type="checkbox"/> Send copy to: _____ | |

The consulting radiologist, in exercising due care and skill, may conduct a patient consultation as deemed necessary. The radiologist will engage with the referrer to consider any further diagnostic imaging requirements that may result from the consultation.

