DIGITAL X-RAY

CLEAR

Radiology Ltd.
Diagnostic Imaging Services
Centralized Scheduling Tel: (520) 733-7226
Centralized Scheduling Fax: (520) 290-8377
Toll Free Tel: 1-866-565-2220 Toll Free Fax: 1-866-707-0750

Walk-In Appointments
Please See Back of Form for a Site Address, Phone Number, and Hours of Operation.

PHYSICIAN'S NAME: _____ PHONE #: (_____) _____ FAX #: (_____) _____

If physician practices at multiple locations, please include address for these results to be sent: _____

PATIENT: (First Name) _____ (Last Name) _____ (Middle Initial) _____

DOB: _____ HOME PHONE: (_____) _____

Radiology Ltd. - Carondelet *is contracted with most insurance plans for Digital X-ray exams, with the exception of Aetna, APIPA, APIPA Senior, Evercare, Coventry, Dept. of Labor, DES Disability Determination, GEHA, and St. Elizabeth. If you have one of these insurance plans, please visit one of our other imaging facilities listed on the back of this form.*

Examination Requested: _____

HEAD & NECK
- ❑ Mandible
- ❑ Facial Bones
- ❑ Nasal Bones
- ❑ Orbits
- ❑ Paranasal Sinuses
- ❑ Skull
- ❑ Neck (soft tissue - not for spine)

CHEST
- ❑ One View (PA)
- ❑ Two Views (PA & LAT)
- ❑ Symptoms include:

❑ Specify

RIBS
- ❑ Unilateral Lt Rt
- ❑ Bilateral
- ❑ Sternum

ABDOMEN
- ❑ KUB
- ❑ Two Views

SPINE AND PELVIS
- ❑ C-Spine (flex & exten only)
- ❑ C-Spine
- ❑ T-Spine
- ❑ Scoliosis Study ***(Camp Lowell only)***
- ❑ L-Spine (flex & exten only)
- ❑ L-Spine
- ❑ Pelvis
- ❑ S I Joints
- ❑ Sacrum & Coccyx

UPPER EXTREMITIES
- ❑ Clavicle Lt Rt
- ❑ Scapula Lt Rt
- ❑ Shoulder Lt Rt
- ❑ A/C Joints
- ❑ S/C Joints
- ❑ Humerus Lt Rt
- ❑ Elbow Lt Rt
- ❑ Forearm Lt Rt
- ❑ Wrist Lt Rt
- ❑ Hand Lt Rt
- ❑ Finger(s) Lt Rt

#: _____

OTHER PROCEDURES
- ❑ Bone Age Study
- ❑ Skeletal Survey
- ❑ Leg Lengths

LOWER EXTREMITIES
- ❑ Hip Lt Rt
- ❑ Bilat Hip w/Pelvis
- ❑ Femur Lt Rt
- ❑ Knee Lt Rt
- ❑ Bilat Knee *(AP standing only)*
- ❑ Tibia/Fibula Lt Rt
- ❑ Ankle Lt Rt
- ❑ Foot Lt Rt
  - ❑ Weight Bearing
- ❑ Heel Lt Rt
- ❑ Toe(s) Lt Rt

#: _____

Other:

Primary Diagnosis: _____ ❑ Evaluation for TB

Signs & Symptoms: _____

Special Instructions:
- ❑ Call report requested (cell phone, pager number, or office backline required): _____
- ❑ STAT
- ❑ Have patient wait
- ❑ Send to my office: ❑ CD or ❑ FILMS
- ❑ Instruct patient to take: ❑ CD or ❑ FILMS

Previous Films: ❑ YES ❑ NO When: _____ Where: _____

Referring Physician's Signature: _____ **Date:** _____

PRINT