

Requesting Dr:

TODAY'S DATE:

Clinic:

WE WILL FAX OR E-MAIL YOUR REPORT TO YOU

Address:

FAX NUMBER:

Phone:

E-MAIL:

RADIOLOGIC CONSULTATION REQUEST

Susan L. Vlasuk, DC · Diplomate, American Chiropractic Board of Radiology

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In sending films for consultation, you agree to be responsible for payment and to seek reimbursement from your patient; *however*, we will look first to L&I or PIP benefits, if available.



INCLUDE L&I OR PIP BILLING INFORMATION BELOW OR ON REVERSE

Patient _____ Age _____ Sex _____ Occup _____

Study submitted _____ Dated _____

(date of study and views on which you want a report)

Cervical template: wanted not wanted (include neut, flex, and ext views)

Complaint(s)

Pain _____

(character and amount; what region?)

Other significant symptom? _____

Duration of symptom(s) _____ Onset: sudden gradual

History

Any trauma? _____

Any surgery (anywhere in FOV, not just spine)? _____

Anything else **particularly noteworthy** in the history or physical exam that might be **applicable** to the radiologic interpretation?

- known pathology or systemic disease?
- neurological signs?
- visible deformity?
- is patient taking any medications?
- any relevant lab findings?

PARTICULAR QUESTION(S) ON THESE FILMS: