

* **THIS IS YOUR ORIGINAL** *

1. **GLUE YOUR BUSINESS CARD
HERE**

2. **RUN COPIES TO WRITE ON**

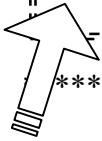
No original business cards, please.

TODAY'S DATE: _____

WE WILL FAX OR E-MAIL YOUR REPORT TO YOU

FAX NUMBER: _____

E-MAIL: _____



RADIOLOGIC CONSULTATION REQUEST

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

875 140th Ave NE, Suite 203, Bellevue, WA 98005 · Phone: (425) 451-1199 [fax 425-454-3953]

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: