Requesting Dr: _____ TODAY'S DATE: _____

Clinic: _____

Address: _____

_____

Phone: _____

WE WILL E-MAIL OR FAX YOUR REPORT TO YOU:

E-MAIL: _____

Reports on digital images are always password-protected and emailed.

FAX: _____

To send you your password – or in cases of reports on film images.

****

R A D I O L O G I C C O N S U L T A T I O N R E Q U E S T

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

914 164th St SE Ste B12-535 Mill Creek, WA 98012 • 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 ATTACHED PAGE

Patient_____ Age_____ Sex_____ Occup _____

Study/views submitted _____ Study date_____

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

Complaint(s)

Pain _____

(character and amount; what region?)

Other significant symptom? _____

Duration of symptom(s) _____ Onset: ◯sudden ◯gradual

History

Any trauma? DOI? _____

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: