LIFE University

LIFE CLINIC SYSTEMS OPERATIONS

Radiology Request Form – Outside Referrals

Patient Legal Name: _____ Request Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Birth: _____ Gender: _____ Height: _____ Weight: _____

Email: _____ Onset Date: _____

Chief Complaint: _____ Diagnosis Code: _____

Reason for X-rays: _____

Radiological Series Requested

Spinal Series

- ☐ Cervical 3v (AP, APOM, Lat)
  - Add: ☐ Obliques ☐ Flex/Ext
- ☐ Toggle 4v (AP, APOM, Lat, Vertex)
  - Add: ☐ Nasium
  - Post: ☐ Nasium ☐ Vertex
- ☐ Thoracic 2v (AP, Lat)
- ☐ Lumbar 3v (AP, Lat, AP-L5 Spot)
- ☐ Full Spine (Digital Stitch)
- ☐ Scoliosis 3v (AP Digital Stitch, Lat T&L)
  - ☐ Scoliosis 1v (AP Digital Stitch)
- ☐ Pelvis 1v
- ☐ Sacrum 2v (AP, Lat)
- ☐ Coccyx 2v

Upper Extremity Series

☐ AC Joint	4v	☐ R	☐ L
☐ Shoulder	3v	☐ R	☐ L
☐ Elbow	4v	☐ R	☐ L
☐ Wrist	4v	☐ R	☐ L
☐ Hand	3v	☐ R	☐ L
☐ Finger	3v	☐ R	☐ L

Finger specification: _____

Lower Extremity Series

☐ Hip	2v	☐ R	☐ L
☐ Knee	4v	☐ R	☐ L
☐ Ankle	3v	☐ R	☐ L
☐ Foot	3v	☐ R	☐ L
☐ Calcaneus	2v	☐ R	☐ L
☐ Toe	3v	☐ R	☐ L

Toe specification: _____

Other Series

- ☐ Chest 2v (PA, Lat) ☐ Clavicle ☐ R ☐ L
- ☐ Ribs (3-5v) ☐ R ☐ L ☐ Scapula ☐ R ☐ L
- ☐ Long Bone 2v (AP, Lat) Specify Area: _____
- ☐ Specify Additional Views: _____

Please complete patient history on next page.

Referring Doctor Name: _____ Phone: _____

Address: _____ Fax: _____

City/State/Zip: _____

Doctor's Signature: _____

Delivery Method:
- ☐ Send copy of films with patient (copy is on a disk) *Final Report to be faxed/mailed*
- ☐ Mail copy of films with final report (copy is on a disk)
- ☐ Doctor will pick up disk and final report

Life Clinics Use Only

LIFE University File #: _____ PEAK: _____

PREGNANCY RELEASE (REQUIRED - FEMALE PATIENTS BETWEEN THE AGES OF 12 AND 65)

This is to certify to the best of my knowledge, I am **NOT PREGNANT**, and hereby give Life University College of Chiropractic Clinics my permission to take X-Rays.

*****TO BE SIGNED THE DAY OF THE X-RAYS*****

Patient Signature: _____ Guardian Signature (if minor): _____

Date Signed: _____ Witness Signature: _____

Please FAX form to 770-426-2998

Call 770-792-6100 with questions

LIFE University

LIFE CLINIC SYSTEMS OPERATIONS

Patient History

File Number: _____

Patient's Name: _____

Request Date: _____

Select "No" or "Yes" for each question below. If yes, provide full details. including nature and duration of illness and dates.

Cancer or tumor of any type?

☐ No ☐ Yes Details: _____

Results of treatment: _____

Any history of kidney, liver, or gallbladder disease, including stones or any endocrine problems (diabetes, pituitary tumors/disorders)?

☐ No ☐ Yes Details: _____

Any history of arthritis, gout, or joint pains? Any neck or back pain or any history of trauma, broken bones, or sprains?

☐ No ☐ Yes Details: _____

Any history of high blood pressure, rheumatic fever, heart murmur or any cardiac complaint? Any blood disorders, AIDS, HIV+, or hepatitis?

☐ No ☐ Yes Details: _____

Asthma, tuberculosis, bronchitis, emphysema, or any other lung illness?

☐ No ☐ Yes Details: _____

Any inpatient or outpatient surgeries or hospitalizations other than surgery? Any medical devices/implants (e.g., pacemaker, insulin pumps, breathing devices, or shunts)?

☐ No ☐ Yes Details: _____

Any tobacco use? If patient smokes or smoked cigarettes; how long and how many packs per day?

☐ No ☐ Yes Details: _____

Any imaging (e.g., x-ray, MRI, CT)?

☐ No ☐ Yes Details: _____

Results: _____

May we request radiologist report? ☐ No ☐ Yes Location: _____

Any history of neurological issues?

☐ No ☐ Yes Details: _____

Life Clinics Use Only

View	Cm	mAs	kVp	FFD	Remarks	View	Cm	mAs	kVp	FFD	Remarks

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