

## DIAGNOSTIC IMAGING REQUEST FORM

**Patient's Name:** 
**Date of Birth:** 
**Tel/Mobile:**

**Gender:**  Male  Female
 **Email Address:** 
**Pregnant**  Yes  No

## REFERRAL DETAILS

**Referring Clinic/Clinician:** 
**Email:** 
**Tel/Mobile:**

## CLINICAL HISTORY

## EXAMINATION REQUESTED

### X-RAY

#### CHEST

- Chest PA & Lat  
 Ribs Left \_\_\_\_\_ Right \_\_\_\_\_  
 Sternum

Other: \_\_\_\_\_

#### SPINE & PELVIS

- Cervical  Scoliosis  
 Thoracic  Pelvis  
 Lumbar  Sacrum/Coccyx

Other: \_\_\_\_\_

#### HEAD & NECK

Body part/Area of Interest:

\_\_\_\_\_

\_\_\_\_\_

#### ABDOMEN

- KUB  
 Acute Abdomen Series

Other: \_\_\_\_\_

#### UPPPER EXTREMITY

- \_\_L \_\_R Shoulder  
 \_\_L \_\_R Scapula  
 \_\_L \_\_R Clavicle  
 \_\_L \_\_R AC Joints  
 \_\_L \_\_R Humerus  
 \_\_L \_\_R Elbow  
 \_\_L \_\_R Forearm  
 \_\_L \_\_R Wrist

Other: \_\_\_\_\_

#### LOWER EXTREMITY

- \_\_L \_\_R Hip  
 \_\_L \_\_R Femur  
 \_\_L \_\_R Knee  
 \_\_L \_\_R Tibia-Fibula  
 \_\_L \_\_R Ankle  
 \_\_L \_\_R Foot

Other: \_\_\_\_\_

### ULTRASOUND

- Abdomen  Breast  Hips  Pelvis  Joint  
 Abdomen and Pelvis  Head  Kidneys and Bladder  Scrotum  Thyroid

Other: \_\_\_\_\_