REFERRAL AND/OR REQUEST(S) FOR CHIROPRACTIC IMAGING

NIDDRIE XRAY

312A Keilor Road, Essendon North, Victoria 3041 | Telephone: 9379 5222
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PATIENT DETAILS:

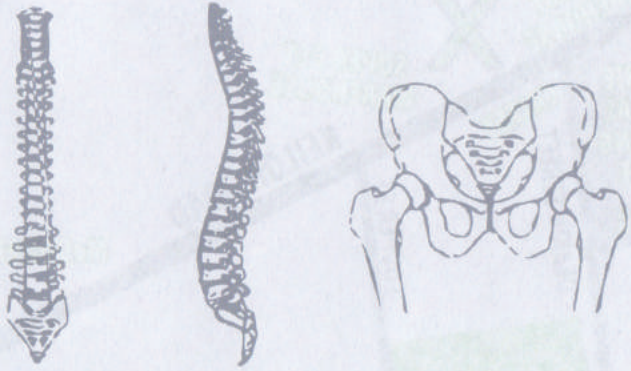
Name: _____ DOB: / /

Address: _____

Telephone: _____ Medicare No: _____

CLINICAL NOTES:

(Please mark area of clinical concern)



For female patients, is there any chance the patient may be pregnant? ☐ Yes ☐ No

REFERRER DETAILS:

Referring Dr: _____ Prov. No: _____

Address: _____

Signature: ✗ _____ Date: / /

IMAGING MODALITY REQUESTED

☐ X-RAY ☐ CT ☐ US

VIEWS REQUESTED

CERVICAL SPINE:	AP OM	☐
	AP LC	☐
	Neutral Lateral	☐
THORACIC SPINE:	AO	☐
	Lateral	☐
LUMBAR SPINE:	AP	☐
	Lateral	☐
	AP Lumbo-Pelvic	☐
	SIJs	☐
FULL SPINAL SERIES:		☐
Additional Views: Obliques:	Cervical	☐
	Lumbar	☐
Flexion/Extension:	Cervical	☐
	Lumbar	☐
	Full Length Spinal Imaging	☐

REPORT

☐ Routine ☐ Telephone Report

☐ Routine with patient ☐ Facsimile Report

☐ Send copy to: _____

The consulting radiologist, in exercising due care and skill, may conduct a patient consultation as deemed necessary. The radiologist will engage with the referrer to consider any further diagnostic imaging requirements that may result from the consultation.