PINNACLE X-RAY

REQUEST FORM

By state law, the information disclosed to Pinnacle Open MRI is confidential, Pinnacle Open MRI will destroy any attached copies after stated purpose has bee fulfilled.

PART 1 PATIENT AND PHYSICIAN INFORMATION

PATIENT NAME:

_____

LAST FIRST MI

SOCIAL SECURITY NUMBER: _____

ADDRESS:

_____

_____

PHONE: _____

DATE OF BIRTH (YYYY/MM/DD) SEX: M / F

_____

MEDICAL PLAN & NUMBER:

_____

REFERRING PROVIDER:

I CERTIFY THAT THIS PROCEDURE IS MEDICALLY NECESSARY FOR THE CARE OF MY PATIENT.

_____

SIGNATURE DATE

ADDRESS:

_____

_____

PHONE: _____

FAX: _____

ADDITIONAL COPIES TO:

_____

REPORTS REQUIRED:

( ) STAT ( )STANDARD WITHIN 24 HOURS

GENERAL X-RAY

❒ C SPINE ❒ COMP ❒ AP/LAT ❒ FLX/EXT

❒ C SPINE ❒ COMP ❒ AP/LAT ❒ FLX/EXT

❒ T SPINE

❒ CHEST ❒ PA ❒ LAT

❒ SACRUM/COCCYX

❒ ABDOMEN

❒ PELVIS

❒ RIBS ❒ L ❒ R

❒ SINUSES

❒ SKULL

❒ ORBITS

❒ OTHER_____

❒ HIP ❒ L ❒ R

❒ FEMUR ❒ L ❒ R

❒ KNEE ❒ L ❒ R

❒ TIBIA/FIB ❒ L ❒ R

❒ ANKLE ❒ L ❒ R

❒ FOOT ❒ L ❒ R

❒ SHOULDER ❒ L ❒ R

❒ HUMERUS ❒ L ❒ R

❒ ELBOW ❒ L ❒ R

❒ FOREARM ❒ L ❒ R

❒ WRIST ❒ L ❒ R

❒ HAND ❒ L ❒ R

❒ FINGER ❒ L ❒ R

❒ LATERAL NECK (ADENOIDS)

❒ AIRWAY

❒ BONE AGE

❒ KUB

ALL SCANS INTERPRETED BY ST. LAWRENCE RADIOLOGY

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