LOGAN UNIVERSITY

CHIROPRACTIC HEALTH CENTERS

DEPARTMENT OF RADIOLOGY IMAGING REFERRAL REQUEST

Patient Name _____ **Date of Birth**_____
Patient Address_____
Patient Telephone_____**Cell**_____ **Gender** □ **Female**
Diagnosis_____ □ **Male**
Insurance_____
Insurance ID_____ **Group #** _____

Note: Imaging Services by Appointment Only
Tel: 636-230-1990 **Fax: 636-207-2436**

RADIOGRAPHY

□ Cervical Spine □ 3 View □ 5 View □ 7 View
□ Lumbar Spine □ 3 View □ 5 View □ 7 View
□ Thoracic Spine □ 2 View
□ Chest □ PA Chest □ 2 View □Apical Lordotic
□ Rib Series □ 5 View □ Right □ Left
□ Full Spine □ FSAP □ FSL
□ Scan-O-Gram (Leg Length)
□ Shoulder □ Right □ Left
□ Elbow □ Right □ Left
□ Wrist □ Right □ Left
□ Hand □ Right □ Left
□ Hip □ Right □ Left □ Bilateral
□ AP Pelvis
□ Knee □ Right □ Left
□ Ankle □ Right □ Left
□ Foot □ Right □ Left
□ KUB
□ Other_____
_____

DIAGNOSTIC ULTRASOUND

	Right	Left	Bilateral
□ Shoulder	□	□	□
□ Elbow	□	□	□
□ Wrist	□	□	□
□ Hand	□	□	□
□ Finger	□	□	□
□ Hip	□	□	□
□ Groin/Hernia	□	□	□
□ Hamstring	□	□	□
□ Quadriceps	□	□	□
□ Knee	□	□	□
□ Lower Leg	□	□	□
□ Ankle	□	□	□
□ Foot	□	□	□
□ Toe	□	□	□
□ Thoracic Cage/Chest	□	□	□
□ Abdominal Wall	□	□	□

□ Thyroid
□ Carotid Screening
□ Other _____

Referring Doctor_____
Referring Doctor Address_____ **Suite** _____
City, State, Zip _____ **e-mail** _____
Telephone _____ **Fax** _____
Billing □ **Bill Patient** □ **Bill Referring Doctor** **License Number** _____
NPI #: _____

Doctor's Signature_____ **Date**_____

Logan University Chiropractic Health Centers – 1851 Schoettler Road –Chesterfield, MO 63017

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