LOGAN
COLLEGE OF CHIROPRACTIC
UNIVERSITY PROGRAMS

DEPARTMENT OF RADIOLOGY IMAGING REFERRAL FORM

Patient Name _____ Date of Birth_____
Patient Address_____
Patient Telephone_____Cell_____ Gender ☐ Female
Diagnosis_____ ☐ Male
Insurance_____
Insurance ID_____ Group # _____
Insurance Address _____

Note: Imaging Services by Appointment Only
Tel: 636-230-1865/Radiography 636-230-1859/Ultrasound Fax: 636-207-2429

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 College of Chiropractic – 1851 Schoettler Road – PO Box 1065 – Chesterfield, MO 63017
Tel: 636-227-2100 or 636-227-0903 Fax: 626-207-2429