MetroDiagnostic Imaging, LLC

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X-Ray Referral

Date: ____________ Referring Physician: ________________________________

Phone: ______________ Fax: ______________ Email: ______________

Patient: ______________ Phone: ______________ DOB: __________ ☐ Male ☐ Female

Address: ______________ City: ______________ State: ________ Zip: ________

Type of Trauma: ☐ Auto Injury ☐ Work Injury ☐ Slip & Fall ☐ Other **History of surgery/malignancy:** ☐ YES ☐ NO

DOI: __________ Insurance: ______________________ Claim#: ______________

Attorney: ______________________________ Phone: ______________

Working Diagnosis *(Check all that apply)*:

☐ Cervical Sprain/Strain ☐ Thoracic Sprain/Strain ☐ Lumbar Sprain/Strain ☐ Lumbosacral Sprain/Strain
☐ Cervical Subluxation ☐ Thoracic Subluxation ☐ Lumbar Subluxation ☐ Pelvic Subluxation
☐ Sacral Subluxation

☐ Other: ____

Symptom Diagnosis *(Check all that apply)*:

☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Headache
☐ Dizziness ☐ Arm Numbness/Tingling/Pain ☐ Sciatica/Leg Numbness/Tingling/Pain ☐ Ligamentous Injury
☐ Muscle Spasm ☐ Decreased ROM

☐ Other: ____

General Medical Necessity *(Check all that apply)*:

☐ Evaluate Ligamentous Instability ☐ Evaluate Increased/Decreased Motion ☐ Confirm Joint Fixation
☐ Confirm/Rule Out Fracture/Dislocation ☐ Confirm/Rule Out Degenerative Changes ☐ Evaluation Of Implant Or Fusion

☐ Other: ____

X-Rays Upright & Weight Bearing

Cervical Spine	Thoracic Spine	Lumbar Spine	Upper/Lower Extremities	
☐ Davis Trauma Series (7 views)	☐ APT	☐ APLP	☐ Shoulder L - R	☐ Hip L - R
☐ APOM	☐ LT	☐ LLS	☐ Elbow L - R	☐ Knee L - R
☐ APLC	☐ PA-Chest	☐ Lumbosacral Spot	☐ Wrist L - R	☐ Ankle L - R
☐ LCN	☐ LAT-Chest	☐ Obliques	☐ Hand L - R	☐ Foot L - R
☐ Flex/Ext	☐ Ribs: __________	☐ Other: __________	☐ Other __________________	
☐ Obliques				

Additional Notes: ____

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Physician Signature: ____