DIAGNOSTIC X-RAY CONSULTATION SERVICES®

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Patient's Name: _____ Date of Birth: _____

Referred by Dr: _____ Dr.'s Phone: _____ Height: _____ Weight: _____

Date Taken: _____ □ Male □ Female

DO NOT WRITE IN THIS SPACE

Date of Report:

CIRCLE ONE: X-RAY ULTRASOUND

Patient's Complaint - PAIN (Where? When? What Relieves? etc.):

Patient's History - (Recent: Trauma, Surgery, Disease, Weight Gain/Loss? History of Cancer? Irradiation Therapy?):

Specific Information Desired - (Please check or circle any areas in question):

Treating Diagnosis (ICD-10 Code):