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IMAGING REQUISITION

Today's Date: ____/____/____ Routine STAT Send CD

Patient Name: _____

DOB: ____/____/____ Female Male

Home Phone: _____ Alt Phone: _____

Clinical Indication for Today's Visit: _____

ICD-9: _____ Insurance: _____ Auth #: _____

Referring Physician: _____

Phone: _____ Fax: _____

Physician's Signature: _____

Patient has been screened for metal or implanted devices.

Soft Tissue Neck
 Arthrogram (specify joint) – R / _____

- Shoulder – R / L
- Elbow – R / L
- Wrist – R / L
- Hand – R / L
- Pelvis
- Knee – R / L
- Ankle – R / L
- Forefoot – R / L

Spine – C / T / L
 Other: _____

Notes: _____

