

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Appt. Preference:  Today  Within 1 week  Specify, within: \_\_\_\_\_ weeks/months

Reason for Exam / Medical Necessity / Symptoms & Duration: \_\_\_\_\_

Dx (All indications): \_\_\_\_\_

SPINE	Views	Specify	With Lift	If Brace
<input type="checkbox"/> Full Spine	PA AP Lat Obl	Standing Recumbent Sitting in WC Sitting out of WC	Right Left _____cm	In brace Out of brace
<input type="checkbox"/> Traction Spine				
<input type="checkbox"/> Cervical	AP Lat Obl Flex Ext Dens Swimmers	Standing Recumbent Sitting in WC Sitting out of WC		In collar Out of collar
<input type="checkbox"/> Thoracic <input type="checkbox"/> ThoracoLumbar	AP Lat Obl Flex Ext Side Bending	Standing Recumbent Sitting in WC Sitting out of WC		In brace Out of brace
<input type="checkbox"/> Lumbar	AP Lat Obl Flex Ext Spot L5-S1 Side Bending	Standing Recumbent Sitting in WC Sitting out of WC		In brace Out of brace
PELVIS	Views	Specify	If Cast	If Brace
<input type="checkbox"/> Pelvis	AP	Standing Recumbent Dangling	On Off	In brace Out of brace With Lift
<input type="checkbox"/> Frog Pelvis	(AP Bilateral Frog Hips)			
<input type="checkbox"/> Hip	AP Judet Frog Lat XTable Lat False Profile	Bilat Right Left		
LOWER Ext	Views	Specify	If Cast	Specify
<input type="checkbox"/> Scanogram Leg Length		<input type="checkbox"/> Bone Age	Right Left	
<input type="checkbox"/> Full Lower Extremity	AP Lat	Bilat Right Left Standing Recumbent	On Off	With Lift Right Left _____cm
<input type="checkbox"/> Femur	AP Lat Obl	Bilat Right Left	On Off	
<input type="checkbox"/> Knee	AP Lat Obl Sunrise Tunnel	Bilat Right Left Max Extension	On Off	Standing Supine
<input type="checkbox"/> Tibia Fibula	AP Lat Obl	Bilat Right Left Max Extension	On Off	AFOs On Off
<input type="checkbox"/> Ankle	AP Lat Mortise Distal Tib/Fib	Bilat Right Left	On Off	Standing Supine
<input type="checkbox"/> Foot	AP Lat Obl	Bilat Right Left Standing	On Off	AFOs On Off
<input type="checkbox"/> Toe specify digit ____	AP Lat Obl	Bilat Right Left	On Off	

Other Exam Requested or Further Instructions:			
UPPER Ext	Views	Specify	If Cast
<input type="checkbox"/> Shoulder	AP Lat Y view Axillary Grashey	Bilat Right Left	
<input type="checkbox"/> Clavicle	AP AP 20° up angle	Bilat Right Left	
<input type="checkbox"/> Scapula	AP Lat Y view	Bilat Right Left	
<input type="checkbox"/> Humerus	AP Lat	Bilat Right Left	On Off
<input type="checkbox"/> Elbow	Distal Humerus AP Lat Obl Proximal Forearm	Bilat Right Left	On Off
<input type="checkbox"/> Forearm	AP Lat	Bilat Right Left	On Off
<input type="checkbox"/> Wrist	PA Lat Obl Scaphoid	Bilat Right Left	On Off
<input type="checkbox"/> Hand	PA Lat Obl	Bilat Right Left	On Off
<input type="checkbox"/> Finger(s) specify digit _____	AP Lat Obl	Bilat Right Left	On Off
<input type="checkbox"/> Scanogram Upper Extremity			
<input type="checkbox"/> Full Upper Ext.	AP Lat	Bilat Right Left	On Off
MISC	Views	Specify	
<input type="checkbox"/> Shunt Series	<input type="checkbox"/> Shunt Valve		
<input type="checkbox"/> Skull	AP Towne Rt Lat Lt Lat		
<input type="checkbox"/> Bone Age Hand		Right Left	
<input type="checkbox"/> Bone Age Hemiskeleton		Right Left	
<input type="checkbox"/> Skeletal Survey			
<input type="checkbox"/> Chest	PA AP Lat	Upright Recumbent Decubitus	
<input type="checkbox"/> Abdomen / KUB	AP Lat Pump Series	Upright Recumbent Decubitus	

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print/ Stamp here

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_