Diagnostic Imaging

A Service of Southern California University of Health Sciences

CHIROPRACTIC
ACUPUNCTURE
DIAGNOSTIC IMAGING
REHABILITATION

REQUISITION FOR X-RAY INTERPRETATION

Patient: ____

Age: _____ Sex: ______

Date Films were Taken: ____________________Patient's Home phone # (____) _____-__________

Name of Dr.: ________________________ Phone# (____)____-_______ Fax# (____)____-_______

Call___ Fax report___

Return films to: ____
number street suite #

____
city state zip code

Do not send payment with films. A bill will be sent to your office (please include your address). Prompt payment is appreciated.

Films for interpretation can be sent to:
Diagnostic Imaging
16200 E. Amber Valley Drive - Whittier, CA 90609

Related trauma? ___No __Yes Date of injury: _________________

Pertinent history and/or concerns to be addressed:

____

____

____

____

____