



## REQUISITION FOR X-RAY EXAMINATION – Whittier/ Pasadena

Patient: \_\_\_\_\_

Age: \_\_\_\_\_ sex: \_\_\_\_\_

Patient's phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
home work

CHIROPRACTIC  
ACUPUNCTURE  
DIAGNOSTIC IMAGING  
REHABILITATION

Referring Dr.: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Call \_\_\_\_\_ Fax report ASAP \_\_\_\_\_

Return films to:

\_\_\_\_\_

number street suite # city zip code

### CIRCLE EXAMINATIONS REQUESTED (Please sign below to authorize exam):

3v C/S 5v C/S (w/obl.) 5v C/S (w/flex. & ext.) 7v C/S 2v T/S 3v T/S (w/chest)  
2v L/S 3v L/S 5v L/S Extremity (specify) \_\_\_\_\_ Other \_\_\_\_\_

**Billing:** (Circle One) Patient pay / Group Ins. (ICD-9 Codes if available \_\_\_\_\_) / Bill Dr.

Med Pay PI lien / W/C - Authorization # \_\_\_\_\_ (We cannot bill W/C without this number)

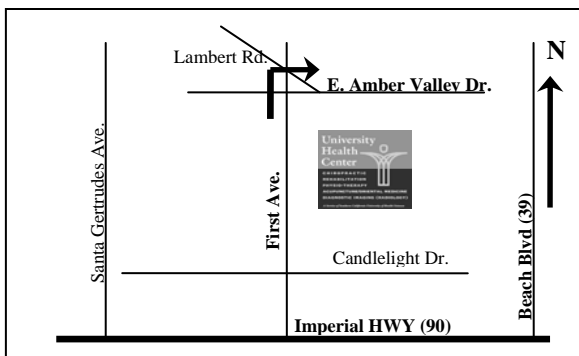
**Payment is expected at time of service unless prior arrangements have been made.**

Related trauma? No Yes Date of injury: \_\_\_\_\_

Any specific concerns to be addressed: \*\*\*\*

**Dr. Signature for authorization** \_\_\_\_\_ \*\*\*\*

**University Health Center – Whittier**  
16200 E. Amber Valley Drive in Whittier.  
Please call for an appointment. **(562) 943-7125**



**University Health Center – Pasadena**  
1450 North Lake Ave in Pasadena.  
Please call for an appointment. **(626) 798-7805**

