National University Of Health Sciences

Diagnostic Imaging Requisition

National University Whole Health Centers

❑ Aurora ❑ Lombard ❑ Chicago ❑ Caruth ❑ Salvation Army ❑ Student Clinic ❑ Referral

Legal Name _____ Date of Study Performed _____
Last, First Middle

Date of Birth _____ Ordering Physician _____ File # _____
Please print legibly

Significant symptoms and/or clinical findings **(all fields required)**:

*Trauma _____

*Surgery _____

*Malignancy _____

Working dx/ddx _____

** Please include dates and type*

X-RAYS ORDERED

❑ C/S 3v/5v/7v
❑ T/S (3v) - includes CXR
❑ L/S 3v/5v
❑ Chest (PA/Lat)
❑ Pelvis (1v)
❑ Hip R/L - includes pelvis
❑ Knee R/L (4v)
❑ Ankle R/L (3v)
❑ Foot R/L (3v)
❑ Shoulder R/L (3v)
❑ Elbow R/L (4v)
❑ Wrist R/L (4v)
❑ Hand R/L (3v)
❑ Abdomen/KUB
❑ Ribs (spot & chest)
❑ Full Spine (7v)
❑ Other _____

Ordering physician's signature: *(Required)*

_____ Date _____

Name of intern taking X-Ray: *(Please print name legibly)*

_____

PREGNANCY RELEASE (REQUIRED FOR X-RAYS)

This is to certify to the best of my knowledge I am NOT PREGNANT and that National University Whole Health Center has my permission to take X-Rays.

First day of last menstrual period:_____

Patient's signature:_____

Date:_____

Witness' signature:_____

DIAGNOSTIC ULTRASOUND ORDERED (Illinois: Student Clinic Only)

❑ Shoulder R/L
❑ Elbow R/L
❑ Wrist R/L
❑ Hand R/L
❑ Hip R/L
❑ Knee R/L
❑ Ankle R/L
❑ Foot R/L
❑ Other _____

Ordering physician's signature: *(Required)*

_____ Date _____

FOR OFFICE USE ONLY *** REQUIRED:** Interns - please complete this chart as radiographs are performed.

VIEW	CM	MAS	KVP	FFD