



**National University
of Health Sciences**
200 E. Roosevelt Road
Lombard, IL 60148

Diagnostic Imaging
Phone: 630-889-6832
Fax: 630-889-6830

Diagnostic Imaging Transmittal Form

Send radiology consultation reports by:

- First-Class mail
- Overnight delivery (charged service)
- Doctor drop-off/pick-up

Also requesting:

- Fax report to clinic
- Immediate phone consultation

Professional questions call:

Dr. William C. Bogar at 630-889-6503
630-889-6832

Billing Information

Physician Information

Doctor's name: _____

Clinic name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Please include a check for \$20 for each X-ray study submitted.

Billing Information

Please complete reverse side.

Patient Information

Patient Information

Patient Name: _____ Date of Birth: _____

Date of onset of signs/symptoms: _____

Is this condition related to: work? auto injury? other injury?

Present Symptoms

Signs/symptoms: _____

Pertinent clinical findings: _____

Diagnosis or impression: _____

If trauma, type and dates: _____

Health History (Please answer 'yes' or 'no' to each of the following and include type and dates)

Trauma? _____ Surgery? _____ Malignancy? _____

If yes, please provide date(s) and describe: _____

Areas of Special Concern

Views Submitted

- | | | |
|--|---|---|
| <input type="checkbox"/> Ankle, 3 Views | <input type="checkbox"/> Foot, 3 Views | <input type="checkbox"/> Shoulder, 3 Views |
| <input type="checkbox"/> Cervical, 3, 5 or 7 Views | <input type="checkbox"/> Full Spine, 7 or 8 Views | <input type="checkbox"/> Thoracic, 2 or 3 Views |
| <input type="checkbox"/> Chest, 2 Views | <input type="checkbox"/> Hand, 3 Views | <input type="checkbox"/> Wrist, 4 Views |
| <input type="checkbox"/> Comparison View | <input type="checkbox"/> Hip, 2 or 3 Views | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Knee, 4 Views | |
| <input type="checkbox"/> Elbow, 4 Views | <input type="checkbox"/> Lumbar, 2, 3 or 5 Views | |

***Please include a check for \$20 for each X-ray study submitted.
MRI Interpretations – \$125 per series.**