Toowoomba
Diagnostic Imaging

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Patient Name _____ Date of Birth _____

Address _____

Contact Details _____ Medicare No _____

Chiropractic (All X-ray examinations performed load bearing unless otherwise requested)

- ☐ Full Spine (inc Pelvis) ☐ AP ☐ Lat
- ☐ C Spine ☐ AP ☐ AP Open Mouth ☐ Lat ☐ Oblique ☐ Flex / Ext
- ☐ T Spine ☐ AP ☐ Lat
- ☐ L/S Spine (inc Pelvis) ☐ AP ☐ Lat ☐ Oblique ☐ Flex / Ext
- ☐ Ultrasound _____

Podiatry (All X-ray examinations performed load bearing unless otherwise requested)

☐ Left ☐ Right ☐ Bilateral ☐ Ultrasound

Dental

- ☐ OPG ☐ Cephalogram ☐ Lat ☐ Frontal
- ☐ TMJoints ☐ Closed & Open ☐ Transcranial ☐ Mandible
- ☐ Other

Region of Interest _____

X-ray

- ☐ Foot ☐ AP ☐ Lat ☐ Oblique
- ☐ Ankle ☐ AP ☐ Lat ☐ Mortise
- ☐ Knee ☐ AP ☐ Lat ☐ Intercondylar
- ☐ Femur (AP and Lat) ☐ Tibia / Fibula (AP and Lat)
- ☐ Other _____

Clinical Hx / Notes _____

Referred By _____ Provider Number _____

Contact Details _____

Signature _____ Date _____

X-ray
OPG/LC
Ultrasound