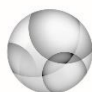

OREGON ADVANCED IMAGING

XRAY SCHEDULING FORM

881 O'Hare Parkway
Medford, OR 97504

Scheduling: (541) 608-0350
Scheduling fax: (541) 608-0376

PATIENT INFORMATION

Patient Name____ Age:______ DOB: ____________

☐ Male ☐ Female **Ht.** __________ **Wt.**__________ SS# ______________________

Home Number (____) __________________ Work/Cell (____) __________________

Primary Insurance ______________________________ Secondary ____________________________

XRAY REQUESTED

HEAD & NECK	CHEST	LOWER EXTREMETIES
☐ Eye Foreign Body	☐ Chest	☐ Pelvis
☐ Facial Bones	☐ Ribs L or R	☐ Hip L or R
☐ Mandible	☐ Sternum	☐ Pelvis w/Hip Bilat
☐ Nasal Bones	☐ Sternoclavicular Joints Bilat	☐ Femur L or R
☐ Sinus		☐ Knee L or R
☐ Skull		☐ Tibia/Fibula L or R
☐ TM Joints Bilat		☐ Ankle L or R
	UPPER EXTREMETIES	☐ Foot L or R
	☐ Clavicle L or R	☐ Toe(s) L or R
SPINE & PELVIS	☐ Scapula L or R	Digit:
☐ CSpine	☐ Shoulder L or R	
☐ LSpine	☐ Acromioclavicular Joints Bilat	
☐ TSpine	☐ Humerus L or R	
☐ Pelvis	☐ Elbow L or R	**ABDOMEN**
☐ Sacroiliac Joints	☐ Forearm L or R	☐ Abdomen
☐ Scoliosis Thoracolumbar AP	☐ Wrist L or R	
	☐ Hand L or R	
	☐ Fingers L or R	**OTHER**
	Digit:	☐______________________
		☐______________________
		☐______________________

Diagnosis / Reason for Exam: ______________________________ **ICD-10 code(s):** ______________

Notes: ____

____

REFERRING OFFICE

Date of referral: ____________________________ Requested appt date:______________________________

Referring Provider Name__________________________

Office Contact Person: __________________________

Phone # (___) ____________ Fax # (___)__________

Signature:

Appt. date has already been scheduled for: Day____________**Date**____________ **Time**__________

Revised: 12/2016

Fax form and all supporting documentation to 541-608-0376