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QUINLAN IMAGING CONSULTATION

# Diagnostic Imaging Consultation Form

## Doctor information

Referring Doctor's Name:_____

Clinic Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Humber:_____ Fax Number:_____

Email:_____ Preferred method to receive report (circle one): Fax/Email/Mail only

Immediate consultation required (circle one): YES/NO

## Patient Information

Patient's name:_____ Gender (circle one): Male/Female

Date of birth:_____ Date of study:_____

Clinical signs and symptoms:_____

Special areas of concern:_____

Working Diagnosis:_____

Surgical history (including dates):_____

History of malignancy or other serious illness (including dates):_____

History of trauma (including dates):_____

**Modality Submitted (circle one):** X-Ray/MRI/CT

If x-ray, please circle the region submitted (mark all that apply):

- Cervical Spine
- Pelvis
- Wrist
- Knee
- Chest
- Full spine (6-7 views)
- Thoracic Spine
- Shoulder
- Hand
- Ankle
- Abdomen
- Lumbar Spine
- Elbow
- Hip
- Foot
- Other:_____

Please include a check made out to Dr. Erin Ruof for the full fee. Thank you for this referral.