Life Chiropractic College West Health Center
X-Ray Request Form

Patient Name: _____ M/F DOB: _____

Field Dr.:_____ Field DR. Acct#: _____

Mailing address_____

Dr. Signature: _____ Dr Telephone #: _____
-Fill out all fields, list best days and time ranges for patient.

-We will schedule with your office directly. Our phone is 510 780-4559
-FAX this form to us at (510) 780-4511.
-A $25.00 fee may be charged if your patient fails to show up for their appointment.
____Bill Doctor's credit card on file _____Patient to pay on day of service

Plain Film X-ray_____ Digital X-ray (CD for computer) _____

Request for DACBR report_____ Note: Billed separately by mail

Cervical X rays
___LAT, APOM, APLC (3 views)
___Cervical obliques (2 views)
___Cervical Flex/Ext (2 views)
___Cervical Lateral bending (2 views)

Thoracic X rays
___AP, LAT (2 views)
___Chest PA (1 view)
___Chest LAT (1 view)

Lumbo-pelvic X rays
___AP,LAT (2 views)
___Lumbar Flex/Ext (2 views)
___Lumbar obliques (2 views)
___Lumbar Lateral bending (2 views)
___Lumbosacral lateral spot (1 view)
___PA sacral tilt (1 view)
___Modified Ferguson (1 view)

___Ankle (3 views) _Left_Right
___Foot (3 views) _Left_Right
___Knee (2 views) _Left_Right
___Hand (3 views) _Left_Right
___Wrist (4 views) _Left_Right
___Elbow (3 views) _Left_Right
___Shoulder(2 views)_Left_Right
___Hip (2 views) _Left_Right
___Other_____

Best days/times for patient:

_____TOTAL number of views

Please do not write below this line:
Appointment scheduled for: Date:_____ Time:_____

For use on day of x ray only by LCCW faculty:
Female Patients: There is no possibility that I am pregnant today.
Patient Signature: _____ Date: _____