SCU HEALTH
INTEGRATIVE HEALTH & MEDICINE

Acupuncture & Eastern Medicine • Ayurveda • Chiropractic • Diagnostic Imaging • Human Performance Optimization
Spine Care • Sports Medicine• Tactical Sports Medicine

REQUISITION FOR X-RAY EXAMINATION – Whittier

Patient: _____ Age: _____ Sex: _____

Referring Dr.: _____ Phone: _____ Fax: _____

Call _____ Fax report ASAP _____ No CD (digital images) needed _____

Give CD (digital images) to patient_____ OR Send CD (digital images) to:

_____

number street suite # city zip code

CIRCLE EXAMINATIONS REQUESTED (Please sign below to authorize exam):

3v C/S 5v C/S (w/obl.) (w/flex/ext.) 7v C/S 2v T/S 2v Chest 2v L/S 3v L/S

5v L/S (w/obl.) (w/flex/ext.) 7v L/S Extremity (specify) _____ Other_____

Billing: (Circle One) Patient pay / Group Ins. **(ICD-9 Codes _____)** / Bill Dr.

Payment is expected at time of service unless prior arrangements have been made.

Related trauma? No / Yes Date of injury: _____

Any specific concerns to be addressed: _____

_____

Dr. Signature for authorization_____

Verification of non-pregnancy: _____

University Health Center – Whittier
16200 E. Amber Valley Drive
Whittier, CA 90604
Please call for an appointment. **(562) 943-7125**