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 10/2016

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