LIFE WEST
HEALTH CENTER

X-Ray Request Form
We will schedule with your office directly.
Our phone is (510) 780-4559
FAX this form to us at (510) 780-4511

Patient Name: _____ M/F DOB: _____

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

Mailing address_____

Dr. Signature: _____ Dr. Telephone #: _____

Digital X-ray (CD for computer)
Extremity X-Rays

Cervical X-Rays

☐ LAT, APOM, APLC (3 views)
☐ Cervical oblique (2 views)
☐ Cervical Flex/Ext (2 views)
☐ Cervical Lateral bending (2 views)
☐ Elbow (3 views) ☐ Left ☐ Right

Thoracic X-Rays

☐ AP, LAT (2 views)
☐ Chest PA (1 view)
☐ Chest LAT (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

☐ Shoulder (2 views) ☐ Left ☐ Right
☐ Hip (2 views) ☐ Left ☐ Right
☐ Other_____

Lumbo-pelvic X-Rays

☐ AP/LAT (2 views)
☐ Lumbar Flex/Ext (2 views)
☐ Lumbar oblique (2 views)
☐ Modified Ferguson (1 view)

☐ Lumbosacral lateral spot (1 view)
☐ Lumbar Lateral bending (2 views)
☐ PA sacral tilt (1 view)

_____**TOTAL** number of views

Best days/times for patient: _____

$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

☐ Request for DACBR report Note: Billed separately by mail

Please do not write below (for LCCW faculty use only):

Appointment scheduled for: Date: _____ Time: _____

Female Patients: There is no possibility that I am pregnant today.
Patient Signature: _____ Date: _____