ROCKY MOUNTAIN CHIROPRACTIC RADIOLOGICAL CENTER

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Contact us if you wish to learn more about summitting digitally.

**PATIENT NAME:**_____ BIRTHDATE: _____ AGE:_____ M *or* F

SERIES:_____

DATE IMAGES TAKEN:_____ NUMER OF IMAGES SENT:_____

SURGERY / TRAUMA / CANCER: _____

SYMPTOMS / CLINICAL FINDINGS / COMMENTS: _____

**REFERRING DOCTOR:** _____ Phone: _____

**CENTER/CLINIC NAME:** _____

ADDRESS: _____

***How do you want to receive your report(s)?*** ❑ FAX:_____

❑ EMAIL:_____ ❑ USPS TO ADDRESS ABOVE