



ROCKY  
MOUNTAIN  
CHIROPRACTIC  
RADIOLOGICAL  
CENTER

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

**PATIENT NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **M or F**

**SERIES:** \_\_\_\_\_

**DATE IMAGES TAKEN:** \_\_\_\_\_ **NUMBER 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