ROCKY MOUNTAIN CHIROPRACTIC RADIOLOGICAL CENTER, LLC

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PATIENT NAME_____ **DOB**_____

REFERRING DOCTOR_____

PHONE_____ **FAX**_____

X-RAYS REQUESTED ☑ ALL THAT APPLY

	CERVICAL SERIES – LIMITED		LUMBAR SPINE W/ OBLIQUES
	CERVICAL SERIES W/ OBLIQUES		PELVIS & HIP(S)
	CERVICAL SERIES W/ FLEX/EXT		OTHER – LIST BELOW
	CERVICAL SERIES – DAVIS SERIES		
	THORACIC SPINE – AP/LATERAL		
	LUMBAR SPINE – LIMITED		

CHIEF COMPLAINT_____

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COMMENTS_____

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