Northwestern Health Sciences University
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EMPLOYEE X-RAY REFERRAL FORM

PATIENT INFORMATION

Patient's Name:			
Sex: M F	Age:	Birthdate:	Occupation:
REFERRING DOCTOR INFORMATION:			
Doctor's Name:			
Clinic Name:			
Address:			
City:	State:	Zip:	
Telephone #:	Fax #:		

X-RAY INFORMATION

Give justification/indications for x-ray			
History of surgery: O No O Yes	History of malignancy: O No O Yes	History of trauma: O No O Yes	
Other pertinent history or clinical findings:			
If patient is female, is there a chance you could be pregnant: O No O Yes Patient's signature:			
EMP:	O Premenarche	O Menopause	O Hysterectomy
Previous x-ray exposure (area, date, and where films were taken):			

#	TFD	B/NB	Film Size	View	CM	MA	Time	MAS	KVP

Referring Doctor’s Signature: _____