



Radiology Transmittal Form

Radiological Consultation Services
 2501 W. 84th St.
 Bloomington, MN 55431-1599
 Phone: (952) 885-5464
 Fax: (952) 886-7565
 Website: www.nwhealth.edu/rcs
Professional questions call:
 Anita L. Manne, DC at (952) 885-5464
 Renée M. DeVries, DC at (952) 855-5411
 Jeffrey A. Rich, DC at (952) 888-4777 ext. 290

Please send more transmittal forms

Date Read: _____
 Study: _____
 Radiologists Initials: _____

Patient Information

Patient's name: _____ Male Female Date of Birth: _____
 Patient's occupation: _____
For third party billing only { Patient's address: _____
 City: _____ State: _____ Zip Code: _____
 Patient's social security #: _____ Home phone #: _____

Referring Doctor Information

Doctor's name: _____ Clinic name: _____
 On File { Billing address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Fax #: _____ E-mail: _____




Insurance Information

Please check only one. If patient has coverage not listed, doctor's office will be billed directly. We can no longer bill BCBS of MN.

Preferred One *(enclose copy of patient's card and intake card)*
 Auto *(we accept 'open' claims only)*
 Claim #: _____ Policy Holder: _____
 Claims Address: _____

 Adjuster's Name: _____ Phone #: _____

Billing

Bill doctor's office
 Check enclosed   
 Bill VISA/Mastercard/Discover *(circle one)*
On File { Name on card: _____
 Card #: _____
 Expiration date: _____

Please complete reverse side.

Personal and Clinical Information

Patient Information

Onset of signs/symptoms: _____

Is this condition related to:

- work?
 auto accident?
 other injury?

Present Symptoms

Signs/Symptoms: _____

Pertinent clinical findings: _____

Diagnosis or impression: _____

If trauma, specify: _____

Health History (please answer yes or no to each of the following)

Trauma? _____ Surgery? _____ Malignancy? _____

If YES, please provide date(s) and describe: _____

Areas of Special Concern

I would like a phone consultation.

Views Submitted

| | DATE |
|--|-------|
| <input type="checkbox"/> Cervical, 2 or 3 views (360) | _____ |
| <input type="checkbox"/> Cervical, 4 or 5 views (361) | _____ |
| <input type="checkbox"/> Davis Series, 7 views (363) | _____ |
| <input type="checkbox"/> Thoracic, 2 or 3 views (366) | _____ |
| <input type="checkbox"/> Lumbar, 2 or 3 views (367) | _____ |
| <input type="checkbox"/> Lumbar, 4 or 5 views (369) | _____ |
| <input type="checkbox"/> Full Spine, 6 or 7 views (365) | _____ |
| <input type="checkbox"/> Chest, 2 views (364) | _____ |
| <input type="checkbox"/> Shoulder, 3 views (370) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Elbow, 4 views (371) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Wrist, 4 views (372) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |

| | DATE |
|--|-------|
| <input type="checkbox"/> Hand, 3 views (373) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Hip, 2 views (369) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Knee, 2 views (374) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Knee, 3 or 4 views (375) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Ankle, 3 views (376) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Foot, 3 views (377) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | _____ |
| <input type="checkbox"/> Comparison View (384) | _____ |
| <input type="checkbox"/> CT or MRI | _____ |
| <input type="checkbox"/> Other: _____ | _____ |