RCS Transmittal Form

2501 W 84th St
Bloomington, MN 55431-1599

Phone: (952) 885-5450
Fax: (952) 886-7565
Billing: (952) 888-4777 ext 245

Professional questions call:
(952) 888-4777
Director Christopher C Major, DC **ext 450**
Anita L Manne, DC **ext 464**
Jeffrey A Rich, DC **ext 290**

For more transmittal forms
please go to ***www.nwhealth.edu/rcs/***

for office use

Date read: ________________
Study: ___________________
Radiologist initials: _________

Patient Information

Patient name:___________________________________ Date of birth: ___________________ Female ☐ Male ☐

Clinic ID:___________________________________ Patient occupation: ____

For third party billing only
Patient address:____
City:____ State:__________ Zip:____________
Phone #:_______________________________________

Referring Doctor Information

Doctor name:____ Clinic:__________________________________

☐ ***On File***
Billing address:____
City:____ State:__________ Zip:________________
Phone #:________________________ ***Fax*** *#:*________________________ E-mail:_________________________

Please note that we ***fax*** *your final, signed report.*

☐ *Check here if you prefer the report mailed to your billing address.*

Insurance Information

Important! *Please remember to provide the patient's address above and the diagnosis code.*

☐ **Preferred One** ***(enclose copy of patient's insurance card)***
☐ **Auto** ***(we accept 'open' claims only)***
☐ **Work Comp**

Claim #: ____
Insurance: ____
Policy holder: ______________________________________
Claims address: _____________________________________
____
Adjuster's name: ____________________________________
Adjuster's phone #: _________________________________

Billing

☐ Bill doctor's office
☐ Bill ***MasterCard/VISA/AmEX/Discover***
☐ Check enclosed

☐ ***On File***
Name on card:___________________________
Card #:_________________________________
Expiration date:________________________

Please complete reverse side.

Current Symptoms

☐ Work related? ☐ MVA? ☐ Other injury?

Clinical signs/symptoms:____

Date of onset: _______________________________ Pertinent exam findings:_____________________________

____

____

Diagnostic code(s): ____

____

Past Health History

Past trauma?___________________ Surgery?___________________________ Malignancy?___________________

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

____

Areas of Special Concern

____

____

☐ I would like a phone consultation. Call ________________________ ☐ OK to leave detailed message.

Views/Study Submitted

	Date of images		Date of images
☐ Cervical, 2 or 3 views	____________	☐ Hip, 2 views	____________
☐ Cervical, 4 or 5 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Davis Series, 7 views	____________	☐ Knee, 2 views	____________
☐ Thoracic, 2 or 3 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Lumbar, 2 or 3 views	____________	☐ Knee, 3 or 4 views	____________
☐ Lumbar, 4 or 5 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Full Spine, 6 or 7 views	____________	☐ Ankle, 3 views	____________
☐ Scoliosis, 2 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Chest, 2 views	____________	☐ Foot, 3 views	____________
☐ Shoulder, 3 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Right ☐ Left ☐ Bilateral		☐ Long bone study, 2 views	
☐ Elbow, 4 views	____________	☐ Right ☐ Left ☐ Bilateral	
☐ Right ☐ Left ☐ Bilateral			
☐ Wrist, 4 views	____________	☐ Comparison Study	____________
☐ Right ☐ Left ☐ Bilateral		☐ CT or MRI	____________
☐ Hand, 3 views	____________	☐ Other:____________	____________
☐ Right ☐ Left ☐ Bilateral			

☐ Images sent electronically.

☐ Images on a disk which I would like returned.

Thanks for the referral. We appreciate it!