VERMONT DIAGNOSTIC IMAGING

426 Industrial Ave, Suite 131, Door A4
Williston, VT 05459
Open Monday-Friday, 8a-4:30p
Phone: 802-988-7226 | Fax: 802-988-7329

☐ **URGENT**

X-RAY & BONE DENSITY ORDER FORM

PATIENT INFORMATION **DATE:** _____

Name: _____ DOB: _____ Phone: _____

Reason for Exam/ICD-10: _____

Ordering Provider: _____ Phone/Fax: _____

HEAD & NECK

☐X-RAY SKULL
☐X-RAY ORBITS
☐X-RAY ORBITS FOR FOREIGN BODY
☐X-RAY SINUSES
☐X-RAY FACIAL BONES
☐X-RAY MANDIBLE
☐X-RAY TMJS (BILAT/OPEN/CLOSED)
☐X-RAY SOFT TISSUE NECK

CHEST

☐X-RAY CHEST ☐1 VIEW ☐2 VIEWS
☐X-RAY RIBS ☐RIGHT ☐LEFT
☐X-RAY RIBS W/ PA CXR ☐RIGHT ☐LEFT
☐X-RAY STERNUM
☐X-RAY STERNOCLAVICULAR JOINTS

ABDOMEN

☐X-RAY ABDOMEN ☐1 VIEW ☐2 VIEWS
☐X-RAY ACUTE BDOMINAL SERIES (W/ PA CXR)

SPINE

☐X-RAY CERVICAL SPINE
☐X-RAY THORACIC SPINE
☐X-RAY THORACO-LUMBAR SPINE
☐X-RAY LUMBAR SPINE

Please indicate views for all spines:

☐AP/LAT ☐OBLIQUES ☐FLEX/EXT
☐BENDING ☐STANDING

SPECIAL EXAMS

☐X-RAY SKELETAL SURVEY
☐X-RAY BONE AGE STUDY
☐X-RAY SHUNT SERIES

Please fax a signed order to 802-988-7329 and we'll call the patient to schedule. **WALK-IN X-RAY** is also available.

PELVIS

☐X-RAY SACROILLIAC JOINTS
☐X-RAY SACRUM/COCCYX
☐X-RAY PELVIS
☐X-RAY HIP ☐RIGHT ☐LEFT

EXTREMITIES

☐X-RAY SHOULDER ☐RIGHT ☐LEFT
☐X-RAY SCAPULA ☐RIGHT ☐LEFT
☐X-RAY CLAVICLE ☐RIGHT ☐LEFT
☐X-RAY AC JOINTS ☐BILATERAL
☐X-RAY HUMERUS ☐RIGHT ☐LEFT
☐X-RAY ELBOW ☐RIGHT ☐LEFT
☐X-RAY FOREARM ☐RIGHT ☐LEFT
☐X-RAY WRIST ☐RIGHT ☐LEFT
☐X-RAY HAND ☐RIGHT ☐LEFT
☐X-RAY FINGER(S) ☐RIGHT ☐LEFT
*Please indicate digit(s):*_____
☐X-RAY FEMUR ☐RIGHT ☐LEFT
☐X-RAY KNEE ☐RIGHT ☐LEFT
☐X-RAY KNEES BILATERAL AP STANDING
☐X-RAY TIB/FIB ☐RIGHT ☐LEFT
☐X-RAY ANKLE ☐RIGHT ☐LEFT
☐X-RAY FOOT ☐RIGHT ☐LEFT
☐X-RAY CALCANEUS ☐RIGHT ☐LEFT
☐X-RAY TOE(S) ☐RIGHT ☐LEFT
*Please indicate digit(s):*_____
☐SPECIAL VIEWS/INSTRUCTIONS:

_____

BONE DENSITY

☐BONE DENSITY AXIAL W/ APPENDICULAR
☐BONE DENSITY AXIAL ONLY
☐BONE DENSITY APPENDICULAR ONLY

PROVIDER SIGNATURE: _____ **DATE:** _____