PIONEER DIAGONISTIC & IMAGING

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Hours Open
Mon - Fri
08:30 am - 06:00 pm
Sat
(By Appointment Only)
09:00 am - 01:00 pm

X - RAY

Chest:
- ☐ PA / Lateral
- ☐ Ribs ☐ L ☐ R
- ☐ Sternum
- ☐ S C joints

Abdomen:
- ☐ KUB / Single
- ☐ Acute (3 views)

Head and Neck:
- ☐ Skull
- ☐ Sinuses
- ☐ Facial Bones
- ☐ Orbits - trauma
- ☐ Orbits - Pre MRI
- ☐ Nose
- ☐ Mandible
- ☐ TMJs
- ☐ Adenoids / Soft Tissue

Spine:
- ☐ Cervical - Osteoarthritis
- ☐ Cervical w Flex/Ext - trauma
- ☐ Thoracic
- ☐ Lumbosacral
- ☐ Sacrum / Coccyx
- ☐ SI joints

Upper Extremity:
Bilat AC joints

- ☐ L ☐ R Clavicle
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Scapula
- ☐ L ☐ R Humerus
- ☐ L ☐ R Elbow
- ☐ L ☐ R Forearm
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand
- ☐ L ☐ R Fingers

Lower Extremity:
- ☐ Pelvis
- ☐ L ☐ R Hip and Pelvis
- ☐ L ☐ R Knee
- ☐ L ☐ R Knee Skyline/standing
- ☐ L ☐ R Tibia/Fibula
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Os Calcis/Heel
- ☐ L ☐ R Toes

1 2 3 4 5

Other: ☐ _____
- ☐ Bone Age
- ☐ Skeletal Survey work-up
- ☐ Arthritic Work-up

ULTRASOUND

General:
- ☐ Full Abdomen
- ☐ Kidneys
- ☐ Bladder (pre & post void)
- ☐ Pelvis + TV
- ☐ Pelvis (without TV)
- ☐ Scrotal/Testicular
- ☐ Thyroid
- ☐ Neck
- ☐ Hernia - Abdo Wall
- ☐ Hernia - Umbilical
- ☐ Small Part:_____
- ☐ Other:_____

ObsGyn:
- ☐ Early Dating
- ☐ IPS (11w-13w6days)
- ☐ Routine
- ☐ BPP/Doppler
- ☐ Recheck / limited
- ☐ Multi-gestation

Date LMP: Day_____ Month_____ Year_____

Cardio-Vascular:
- ☐ Venous
- ☐ Arterial
- ☐ Carotids
- ☐ Renals Arterial
- ☐ L ☐ R Leg
- ☐ L ☐ R Leg
- ☐ L ☐ R Arm

Musculoskeletal:
- ☐ L ☐ R Hip
- ☐ L ☐ R Hamstring
- ☐ L ☐ R Knee
- ☐ L ☐ R Ankle
- ☐ L ☐ R Achillies
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Elbow
- ☐ L ☐ R Wrist
- ☐ L ☐ R Digits

1 2 3 4 5

Other: _____

Breast Imaging: _____

☐ L ☐ R

OTHER TESTS

- ☐ PFT
- ☐ DEXA
- ☐ EKG
- ☐ ECHO
- ☐ Home Sleep Study
- ☐ CT Breast Mammogram
- ☐ ABI
- ☐ Physical Therapy
- ☐ _____

PATIENT INFORMATION:

Date: _____ Gender: _____ DOB: _____

Name: _____

Address: _____ City: _____

Home P#: _____ Cell P#: _____

ZIP: _____

Insurance : _____

Subscriber ID: _____

ICD 10: _____

Reason for Exam: _____

REFERRING PHYSICIAN :

_____ : Name

_____ : NPI

_____ : Office Phone

_____ : Fax Number

_____ : Signature

☐ STAT

Please bring this form to your examination | Walk in appointments available