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AUSTRALIAN **RADIOLOGY** CLINICS

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# Chiropractic Examination Request

Patient's Name ____________________ Date of Birth ____________

Patient's Address ____________________________________

## Clinical Details

## Request For

*Please Tick Required Series of Individual*

### ☐ STANDARD SERIES
(all views performed at 180cm), erect position:

| AP | Lateral |
|---|---|
| **Cervical**<br>☐ AP C1 – C3 (Open Mouth)<br>☐ AP C3 – T1 | ☐ Lateral C1 – T1 |
| **Thoracic**<br>☐ AP T1 – T12 | ☐ Lateral T1 – T12 |
| **Lumbo-Pelvic**<br>☐ AP T12 - Pelvis | ☐ Lateral T12 – Coccyx |

### ☐ NOLAN FILTER VIEWS
(all views performed at 180cm), erect position:

| AP | Lateral |
|---|---|
| ☐ AP C1 – T8 | ☐ Lateral C1 – T8 |
| ☐ AP T8 – Pelvis | ☐ Lateral T8 - Coccyx |

### ADDITIONAL VIEWS
(all views performed at 180cm), erect position:

Obliques: ☐ C – Spine ☐ T – Spine ☐ L - Spine

| | |
|---|---|
| ☐ Hibb's View (AP Sacrum 15°) | ☐ PA L5 – S1 (Down Tilt) |
| ☐ Davis Series (Flex/Ext and Obliques) – Cervical spine | ☐ AP C1 – T1 (Open Mouth) |

Other ____________________________________

**Urgent Chiropractic Radiology Report** ☐

## Location

☐ **Salisbury Centre**
133 Frost Road
Salisbury South SA 5106
**Tel** (08) 8256 9000
**Fax** (08) 8256 9072

☐ **Brighton Centre**
394 Brighton Road
Hove SA 5048
**Tel** (08) 8296 7288
**Fax** (08) 8296 7244

✔ Chiropractic Radiology Report

Doctor's Name, Address and Provider Number

PRO CHIROPRACTIC RADIOLOGY

| Doctor's Signature | | Date | |
|---|---|---|---|
| Appointment Details | Day | Date | Time am/pm |

Please bring this request form, your Medicare card and any relevant previous X-ray with you.