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

AUSTRALIAN RADIOLOGY CLINICS
INNOVATIVE QUALITY SERVICE

Email info@radiologyclinics.com.au
Website www.radiologyclinics.com.au

Chiropractic Examination Request

Name

Address

Date of Birth

Telephone

Medicare Number

Clinical Details

Request for: *Please Tick Required Series or Individual Views:*

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

	AP	Lateral
Cervical	☐ AP C1 – C3 (Open Mouth) ☐ AP C3 – T1	☐ Lateral C1 – T1
Thoracic	☐ AP T1 – T12	☐ Lateral T1 – T12
Lumbo-Pelvic	☐ AP T12 – Pelvis	☐ Lateral T12 – 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 _____

_____

_____

Location

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

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

Doctor's Name, Address and Provider Number

Doctor Signature _____ **Date** ___ / ___ / _____

Appointment Details

Day Date / / Time am / pm

Your referrer has recommended you use Australian Radiology Clinics, you may choose another provider but please discuss this with your referrer first. Please bring this request form, your Medicare card and any relevant previous X-rays with you.

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