Australian Radiology Clinics Pty Ltd
Administration
133 Frost Road, Salisury South SA 5106
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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 ☐ 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

☐ 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 _____

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

Urgent Chiropractic Radiology Report ☐

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.