


REFERRAL FOR RADIOGRAPH BY PHYSICAL THERAPIST

INFORMATION ABOUT THE PATIENT:

Patient Name	
Phone Number	
Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Other - please specify:
Insurance Carrier and Policy Number <i>(or attach copy of insurance card(s) front and back)</i>	Coverage status for radiographs ordered by PT listed here courtesy of Rhode Island Medical Imaging: https://tinyurl.com/xrayinsurance 

CLINICAL PRESENTATION:

Date of Symptom Onset		<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic
Mechanism of Injury			
Symptoms <i>(include as many signs and symptoms as possible)</i>			
Exam Findings <i>(include relevant/significant findings)</i>			

REASON FOR RADIOGRAPH:

Suspected Clinical Diagnosis <i>(be as specific as possible)</i>	
Other Comments	

REPORTING TO PRIMARY CARE PHYSICIAN:

Pursuant to statute 5-40-23b of the R.I. General Laws, Physical Therapists are required to report diagnostic imaging test results to the patient's primary care physician. If the first option is selected below, please note that it is the responsibility of the PT to verify that the results were sent as requested.

Primary Care Physician <i>(enter PCP name)</i>	
Mechanism for Sending Radiology Report to the Primary Care Physician	<input type="checkbox"/> Radiology facility should send results to PCP
	<input type="checkbox"/> Physical Therapist will send results to the PCP
	<input type="checkbox"/> Patient does not have a PCP

BODY LOCATION:

Side of the Body	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Region			
<input type="checkbox"/> Abdomen - KUB	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Leg Length	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Abdomen - Flat/Upright	<input type="checkbox"/> Femur	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> SI Joints
<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> Sinuses
<input type="checkbox"/> Bone Age	<input type="checkbox"/> Forearm	<input type="checkbox"/> Orbits for Foreign Body	<input type="checkbox"/> Skull
<input type="checkbox"/> Calcaneus	<input type="checkbox"/> Foot	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Hand	<input type="checkbox"/> Ribs	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Chest	<input type="checkbox"/> Hip	<input type="checkbox"/> Ribs with PA Chest	<input type="checkbox"/> Tibia/Fibula
<input type="checkbox"/> Clavicle	<input type="checkbox"/> Humerus	<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Toe
<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee	<input type="checkbox"/> Scoliosis Screening	<input type="checkbox"/> Other (describe below)
Comments			

RADIOGRAPHICAL VIEWS ORDERED:

Views Ordered <i>(please specify)</i>	
Radiologist's Discretion	<input type="checkbox"/> Radiologist may use their discretion to perform additional views beyond those ordered herein

General guidelines for ordering x-rays are listed here courtesy of Rhode Island Medical Imaging www.tinyurl.com/xrayviews



REFERRING PROVIDER INFORMATION:

PT Name	
Signature	
NPI Number	
Date	
Employer	
Employer Address	
Employer Phone	
Employer Fax	

RADIOLOGY FACILITY LOCATIONS:

Rhode Island Medical Imaging
<https://rimirad.com/locations>



XRA Medical Imaging
<https://tinyurl.com/XRALocations>



Advanced Radiology
<https://tinyurl.com/ARLocations>



Patients should always call ahead to confirm hours of operation