

Colorado Chiropractic Radiological Center

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Interpretation Request Form

Requesting Physician/Clinic: _____		Clinic # _____
		Fax # _____
Patient Name _____		
Date of Birth _____		
Date of examination _____		
Working diagnosis (s) _____		
Previous diagnosis, medical conditions, surgery, cancer, trauma, etc. (Date, outcome) _____		

Previous studies (plain film, CT, MRI, etc) (Date, findings)		

Special instructions: _____		

Return: Hold films/report for doctor	Mail films/report to doctor	Please fax report and send films
Date of Service _____		
Dx: _____ CPT: _____ Charge _____		

All charges are due 45 days from date of service. All invoices will be sent to the patient if denied or past 45 days.		