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Patient Name: _____ DOB: _____

Diagnosis/ History/ Symptoms: _____

Date: _____ Facility: _____

PEDIATRIC/ADULT CT SCANS	X-RAYS	ULTRASOUND
Order BUN & Creatinine if patient is diabetic, over 50 or hx of renal disease		
<input type="checkbox"/> Head <input type="checkbox"/> Sinus/Maxillofacial <input type="checkbox"/> Temporal Bone <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Without <input type="checkbox"/> With <input type="checkbox"/> With/Without	<input type="checkbox"/> Skull <input type="checkbox"/> Sinus <input type="checkbox"/> Facial Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Cervical Spine <input type="checkbox"/> 4 View <input type="checkbox"/> AP / LAT <input type="checkbox"/> Clavicle <input type="checkbox"/> Chest <input type="checkbox"/> 1 View <input type="checkbox"/> PA / LAT <input type="checkbox"/> Ribs <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Abdomen <input type="checkbox"/> 1 View <input type="checkbox"/> 2 View <input type="checkbox"/> Pelvis Upper Extremity <input type="checkbox"/> Hand <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT Lower Extremity <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Tibia / Fibia <input type="checkbox"/> Knee <input type="checkbox"/> Standing <input type="checkbox"/> Femur <input type="checkbox"/> Hip <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	<input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta <input type="checkbox"/> Bladder <input type="checkbox"/> Gallbladder <input type="checkbox"/> Liver <input type="checkbox"/> Bio-Physical <input type="checkbox"/> OB BPD/FL(13-19 wks) <input type="checkbox"/> OB Complete(20-40 wks) <input type="checkbox"/> OB Multiple Gestation <input type="checkbox"/> OB Pelvic(up to 12 wks) <input type="checkbox"/> Pelvic <input type="checkbox"/> Renal <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid Vascular <input type="checkbox"/> Arterial Doppler <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Bilat <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> W/Exer. <input type="checkbox"/> W/O Exer. <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Bilat <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Renal Artery Doppler
Pediatric CT Scans Only		
<input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar		
<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Without <input type="checkbox"/> With <input type="checkbox"/> With/Without		
<small>With Contrast studies done only at a health care facility</small>		
<input type="checkbox"/> Other _____ _____ _____ _____		

Physicians Signature: _____