X-ray Request Form

If you require XXXXXX Name Of Clinc XXXXX to take an X-ray of one of your patients, please complete the following details.

To be completed by the patient:

Name: _____ D.O.B.: _____

Address: _____

_____

_____

Phone Numbers: 1) 2)

I have been informed of the clinical need for an appropriate X-ray examination, and I consent to this procedure.		Tick boxes as appropriate
If you are under 16 years of age, the consent needs to be signed by a parent / legal guardian.		
I am not pregnant / I may be pregnant, but have had the risks of radiation explained to me, and the reason why an X-ray examination is necessary for my care, and I hereby consent to be X-rayed as requested.		

I am aware of the fees involved for having x-rays taken, and agree to pay XXXXXXXXXXXX on the date of my appointment. Patients are asked to note that any X-rays taken or ordered by a chiropractor must be retained by the chiropractor as part of your health record, for a period of 8 years after the date of your last visit. This is one of the legal requirements of the code of practice published by the General Chiropractic Council, which is the statutory regulator for Chiropractors in the UK.
Under the Data Protection Act, you are entitled to a copy of your health record, including X-Rays (where copying facilities exist), and your chiropractor may make a reasonable charge for the copy.

Signed: _____ Date: _____

(Please indicate whether signature is that of the Patient / Parent / Legal Guardian)

To be completed by the Chiropractor requesting the X-Rays:

I have made a clinical examination of this patient and now request an x-ray examination. This patient meets the following criterion / a.

50+ / Tra / Neu / Uwl / Art / DAA / Mal / Ste / Pyr / Sco / Sur / FTI / EBF / Pos / LEP

Other indications:

_____

Signed: _____ (chiropractor) Date: _____

Practice Name: _____ Phone: _____

Please take the following X-Rays of the above patient:

Cervical A-P O-M LAT Thoracic A-P LAT Lumbo-Pelvic A-P LAT

Other Views:

_____

Notes:

_____

KEY

50+	Aged 50 or over	Tra	Neurological Deficit	UWL	Unexplained weight loss	Art	Inflammatory Arthropathy	DAA	Drug or Alcohol Abuse
Mal	Malignancy	Ste	History of use of Steroids	Sur	Surgery in region of interest	Sco	Investigation of Scoliosis	Pyr	Pyrexia
FTI	Failed to improve with Conservative Treatment	EBF	Equivocal Biomechanical Findings	Pos	Investigation of Extreme Postural Anomaly	LEP	Clinical Examination Limited by Pain		