



# Chiropractic Order Form

**Geneva**

P: 630.208.9325  
F: 630.208.9326  
High-field MRI, CT, Arthrograms,  
Mammography, Bone density,  
Ultrasound, X-ray

**Lake in the Hills**

P: 847.458.6736  
F: 847.458.6700  
High-field MRI, CT, Arthrograms

Appointment Date and Time	Check-in Time	Patient DOB	<input type="radio"/> M <input type="radio"/> F
Patient Name (as shown on insurance card)	Primary Phone #	Secondary Phone #	
Insurance Name	Insurance ID #	Group #	
<input type="radio"/> Auto <input type="radio"/> Workers' Comp <input type="radio"/> Commercial/Private	Date of Injury	Pre-authorization #	

**(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s).** Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

**Is the exam/procedure related to an injury?**  No  Yes **If yes,**  Initial,  Subsequent or  Sequela

**REPORTING METHOD:**  Routine  Read & Call Report  STAT  **Fax report to:**

**LAB RESULTS\*** Creatinine \_\_\_\_\_ Blood Draw Date \_\_\_\_\_  Creatinine On-site Testing at CDI

*\*Lab values needed within 30 days of the exam for IV contrast if the patient 1) is diabetic, 2) is 60 years or older, 3) is having chemotherapy or 4) has only one kidney*

**MRI**  **CT**

**IV Contrast as clinically indicated by radiologist OR**  **No Contrast**

**L**  **R**  **BIL**

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Arthrogram \_\_\_\_\_

**NEURO**

Neck (soft tissue)

TMJ - *CT ONLY*

Other \_\_\_\_\_

**SPINE**

Cervical

Thoracic

Lumbar

**MSK**

Extremity \_\_\_\_\_

Joint \_\_\_\_\_

**OTHER**

Screening to rule out metal (X-ray or CT, as available)

Other \_\_\_\_\_

**X-RAY**

**L**  **R**  **BIL**

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Area of Body \_\_\_\_\_

Views \_\_\_\_\_

**BONE DENSITY**

Screening or  Diagnostic

History of pathological fracture?

No  Yes

Age-related osteoporosis w/o current pathological fracture?

No  Yes

Estrogen deficiency/clinical risk for osteoporosis?

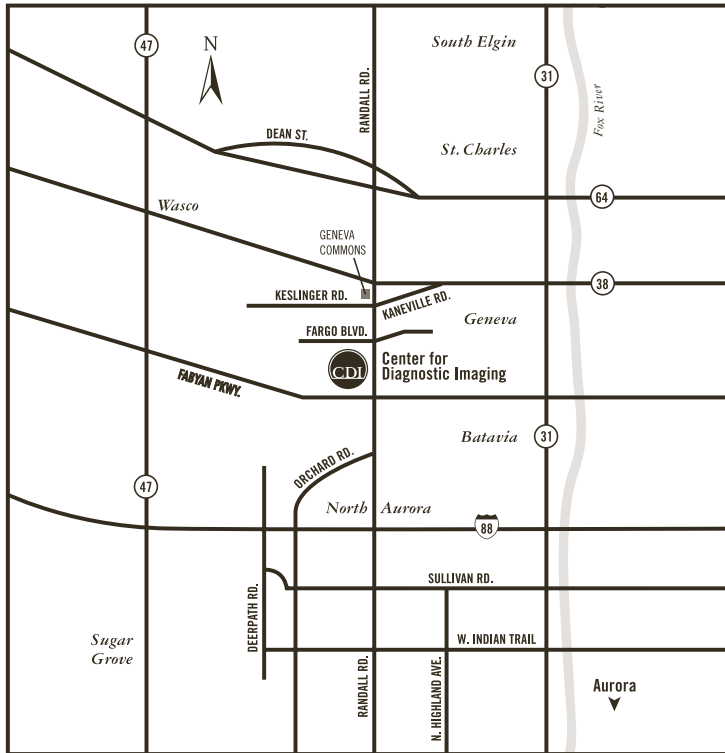
No  Yes

Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids?

No  Yes

Provider Name (Print)	Phone #
<b>(REQUIRED) Provider Signature</b> Provider signature required. Do not use rubber stamp.	Ordering Provider's NPI #
	Date

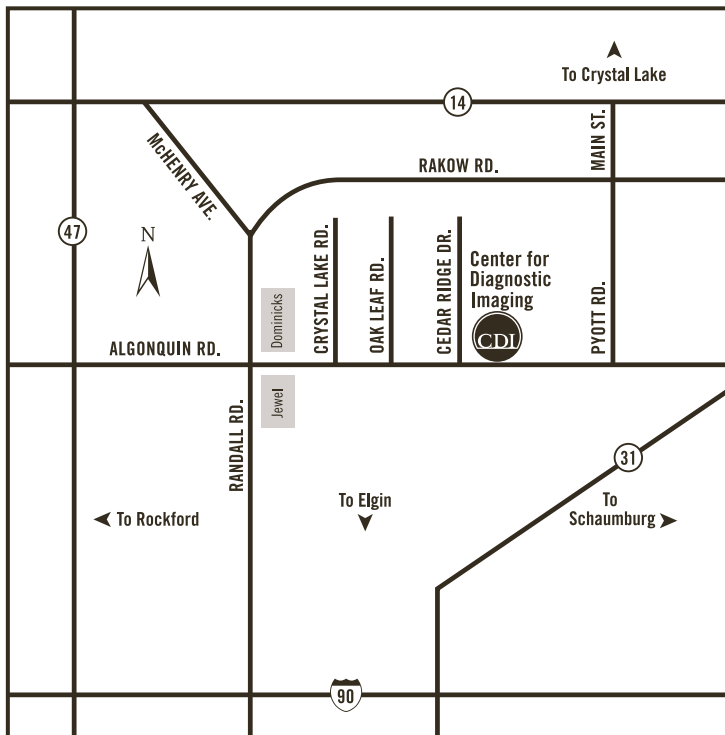
CENTER FOR  
DIAGNOSTIC IMAGING®



**Geneva**

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**Lake in the Hills**

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