Dr. Victor Y. Tong, DC, DACBR
Radiological Consultant
17931 Calle Los Arboles, Rowland Heights
CA 91748 (626) 913-3013

Request for x-ray interpretation

Doctor: _____ Phone: _____

Address: _____ { } check if you want a faxed result

_____ Fax: _____

Patient name: _____ Date of birth: _____Gender: _____

Examination type: _____Number of views: ____Date of exam: _____
Examination type: _____Number of views: ____Date of exam: _____
Examination type: _____Number of views: ____Date of exam: _____

Describe patient's chief complaint:

Describe any pertinent physical findings, orthopedic or neurological signs.

Describe any history of trauma. Please describe when and how it occurred.

Indicate any history of malignancy.

What is your our working diagnosis, ICD9 code?

Do you have any specific questions on the films?