TEXAS
DIAGNOSTIC RADIOLOGY

Email: Orders@texasdiagnosticradiology.com
Website: https://texasdiagnosticradiology.com/
Phone: 214-831-6640
Fax: 469-437-8844

- ☐ Dallas Proper
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- ☐ McKinney
- ☐ Richardson
- ☐ Rowlett
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- ☐ Denton County

Physician Order Form

Patient Information

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Patient Email: _____

DOB: _____

Gender: _____

Height: _____ Weight: _____

Patient Information

Referring Physician: _____

Referring Clinic: _____

Diagnosis: _____

Phone: _____

Email: _____

Fax: _____

Consulting Physician: _____

◯ MRI ◯ CT ◯ X-Ray

Head & Neck

- ☐ Brain
- ☐ Neck Soft Tissue
- ☐ TMJ
- ☐ Face
- ☐ IAC / Pituitary
- ☐ Orbits

Body

- ☐ Abdomen
- ☐ Abdomen / MRCP
- ☐ Abdomen / Kidneys
- ☐ Abdomen / Adrenal Glands
- ☐ Abdomen / Liver
- ☐ Brachial Plexus
- ☐ Pelvis Soft-Tissue
- ☐ Bone Pelvis
- ☐ Sacrum / Coccyx
- ☐ Chest

Musculoskeletal

☐ Ankle	◯ L	◯ R
☐ Clavicle	◯ L	◯ R
☐ Elbow	◯ L	◯ R
☐ Femur	◯ L	◯ R
☐ Finger	◯ L	◯ R
☐ Foot	◯ L	◯ R
☐ Forearm	◯ L	◯ R
☐ Hand	◯ L	◯ R
☐ Heel	◯ L	◯ R
☐ Hip	◯ L	◯ R
☐ Humerus	◯ L	◯ R
☐ Knee	◯ L	◯ R
☐ Shoulder	◯ L	◯ R
☐ Tibia / Fibula	◯ L	◯ R
☐ Toes	◯ L	◯ R
☐ Wrist	◯ L	◯ R
☐ Other: _____	◯ L	◯ R

Contrast

◯ With ◯ Without ◯ With & Without

Spine

- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine

MRA

- ☐ Brain / Head / Circle of Willis
- ☐ Neck / Carotid

Attorney Information

ICD-10 Code / Diagnosis: _____

Attorney name: _____

Attorney number: _____

Attorney email: _____

Date of injury: _____

- ☐ MVA
- ☐ Slip and Fall

Physician's Notes

Applicable patient history description

_____

_____

_____

Specify exam if not listed: _____ Additional notes: _____

Physician signature: _____ Date: _____