9000 Waukegan Road Suite # 110
Morton Grove, IL 60053
P: 847-213-2700 F: 847-213-2709
www.3Timaging.com

Referral Form for Podiatry

PATIENT'S NAME: ______

DATE: ______ AGE: ______

PATIENT'S PHONE NUMBER: ______

CLINICAL HISTORY/INDICATION: ______

ICD-9: ______

RQI #: ______

Pre-Certification #: ______

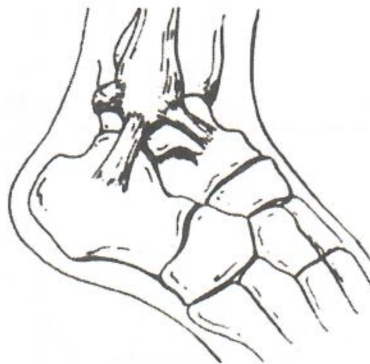
☐ Right ☐ Left ☐ Bilateral

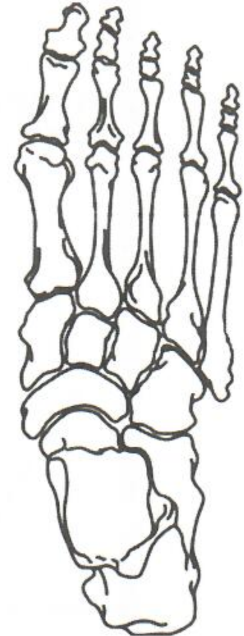
ULTRASOUND: Performed by Brian Kincaid, D.C.
Bilateral peripheral neuro & musculoskeletal study
AREA OF INTEREST:
DVT
Arterial Doppler
Other

			MRI:
w/o	w w/o		Individual Digit (Please specify)
w/o	w w/o		Forefoot/Midfoot
w/o	w w/o		Ankle (Includes Midfoot/Hindfoot)
		w	MR Angiogram Runoff
			Other

			CT:
w/o	w w/o		Forefoot/Midfoot
w/o	w w/o		Ankle (Includes Midfoot/Hindfoot)
		w	CT Angiogram Runoff
			Other

X-RAY:





Physician: ______

Physician Signature: ______

Phone #: ______

Fax #: ______