



DIGITAL HEALTH SERVICES

8873 9999

CHIROPRACTIC REFERRAL

PATIENT DETAILS

Patient Name _____

Address _____

Date of Birth _____

Tel _____

EXAMINATION REQUIRED

- CERVICAL SPINE
 - A.P.
 - A.P. Open Mouth
 - Lateral Neutral ERECT
 - Lateral Flexion/Extension
 - Cervico – Thoracic Junction
 - Obliques
- THORACIC SPINE
 - A.P. SUPINE
 - Lateral
- LUMBAR SPINE
 - A.P. Lumbo – Pelvic View
 - Lateral Neutral
 - Lateral Flexion/Extension
 - Obliques
 - L5/S1
- PELVIS
 - A.P. (to include full pelvis and ischial tuberosities on 35x43cm)
 - Lateral
- OTHER REGION

CLINICAL NOTES

Referrer's Signature

Provider No

Date