



# DIAGNOSTIC IMAGING NETWORK

## Referral Form

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Examination Requested: \_\_\_\_\_

Clinical Impression / Diagnosis: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\* Please check the desired location below\**

**GLENDALE-CENTRAL**

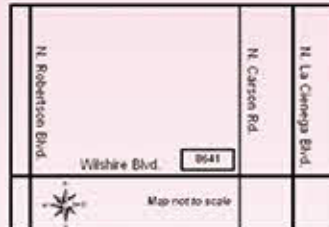
800 S. Central Ave. #100B  
Glendale, CA 91204  
Tel: (818) 548-8333  
Fax: (818) 548-7888



- ◆ DEXA / Bone Density
- ◆ Cardiac Echo
- ◆ Digital Mammography
- ◆ MRI - 1.5T
- ◆ MRA
- ◆ Ultrasound / Transvaginal
- ◆ US Guided Biopsy
- ◆ X-RAY - Skeletal

**BEVERLY HILLS**

8641 Wilshire Blvd. #105  
Beverly Hills, CA 90211  
Tel: (310) 919-3330  
Fax: (310) 854-1860



- ◆ MRI - 1.5T
- ◆ X-RAY - Skeletal

**GLENDALE-PET/CT**

403 S. Glendale Ave.  
Glendale, CA 91205  
Tel: (818) 546-1929  
Fax: (818) 546-1930



- ◆ CT Scan
- ◆ CT-Angiography
- ◆ PET
- ◆ PET/CT
- ◆ PET - Bone Scan

**SHERMAN OAKS**

4910 Van Nuys Blvd. #108  
Sherman Oaks, CA 91403  
Tel: (818) 986-8215  
Fax: (818) 986-9582



- ◆ CT Scan
- ◆ DEXA / Bone Density
- ◆ Mammography
- ◆ MRI - Upright / Positional
- ◆ MR - Arthrogram
- ◆ Ultrasound / Transvaginal
- ◆ X-RAY - Skeletal

**ONLY FOR PERSONAL INJURY REFERRAL**

Date of Injury: \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_