254 Republic Avenue
Joliet, IL 60435

www.futurediagnosticgroup.com

Imaging for a healthier future
Future Diagnostics Group
& Women's Center for Breast Health

Phone: 815-730-3344
Fax: 815-730-3888

Patient Name: _____

Age:_____ D.O.B.:_____ Patient Phone:_____

Referring Physician:_____ Referring Physician Phone:_____

Referring Physician Signature:_____ Referring Physician Fax:_____

Symptoms/Diagnosis: _____

Allergies: _____

Please bring all insurance information with you. Preparations are required for these exams

LAB (required for patient 60 yrs or older or a Diabetic within 6 weeks)

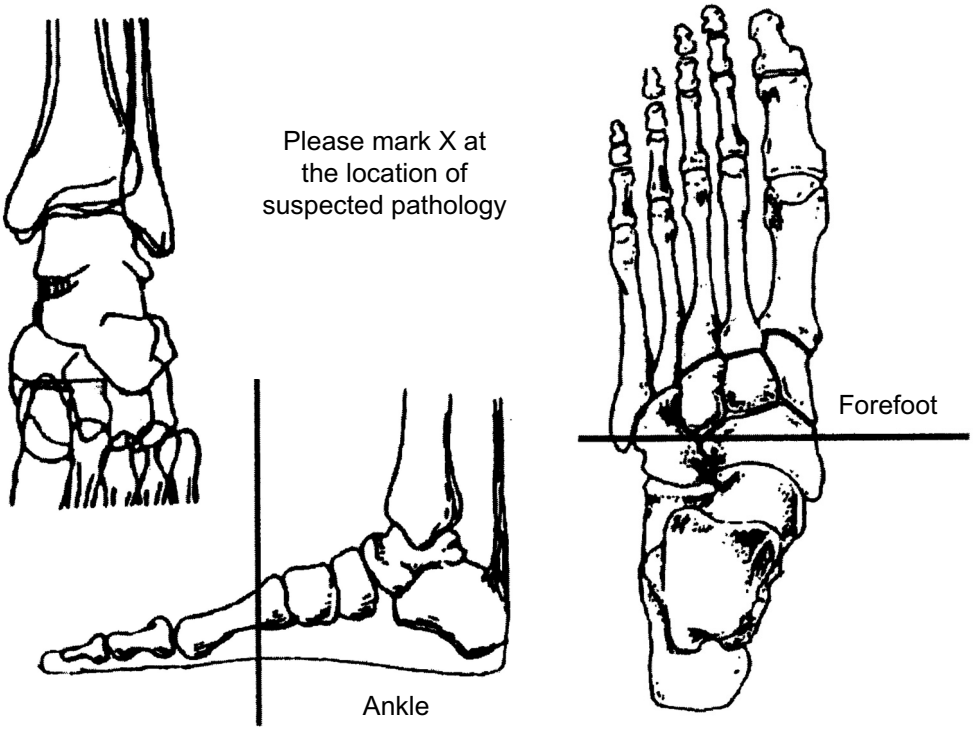
❑ BUN/Creatinine(GFR)

Pre-Certification #

_____

❑ MRI ❑ CT ❑ X-Ray

❑ Plain ❑ With & Without



❑ CD to Patient ❑ Films to Patient

IMAGE THE FOLLOWING

Ankle/Mid/Hind Foot
❑ Mid Foot ❑ Ankle
❑ Right ❑ Left ❑ Bilateral

Forefoot
(metatarsals & phalanges)
❑ Right ❑ Left ❑ Bilateral

INDICATIONS

❑ _____ Tendon Pathology
❑ Fracture or Contusion
❑ Heel Pain
❑ Ligament Injury
❑ Mass (ganglion, neuroma, etc.)
❑ Osteomyelitis
❑ Plantar Fibromatosis
❑ Talar Dome Lesion
❑ Tarsal Coalition
❑ Tarsal Tunnel
❑ Other _____
❑ Contrast
❑ **Contrast at the discretion of Radiologist**
❑ History of Renal Disease

Additional Instructions or Comments: _____

I hereby authorize Future Diagnostics Group to provided treatment, **release and obtain any previous exams or reports** pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney, if applicable in this case.

Patient's Signature **Date** **Physician's Signature** **Date**

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Please send all previous exams and reports to our office prior to the schedule exam.

We are referring you to Future Diagnostic Group (FDG), LLC imaging facility to have your ordered scan(s) performed. Please note that we have an indirect financial relationship with this facility. You are under no obligation to have your testing performed at this facility.