

Date of Appointment: _____ Time of Appointment: _____ am/pm

- /__ / AC Joint R / L
- /__ / Ankle AP/Lat/Mortise R / L
- /__ / Chest PA/Lat R / L
- /__ / Clavicle R / L
- /__ / Elbow AP/Lat/Obliques R / L
- /__ / Femur AP/Lat R / L
- /__ / Finger or Fingers R / L
- /__ / Foot AP/Lat/Oblique R / L
- /__ / Forearm R / L
- /__ / Hand AP/Lat/Oblique R / L
- /__ / Hip AP/Lat R / L
- /__ / Hip 1 View R / L
- /__ / Hip AP/Judet Views R / L
- /__ / Humerus AP/Lat R / L

- /__ / Knee AP/Lat R / L

- /__ / Knee AP/Lat/Obliques R / L

- /__ / Knee AP/Lat/Sunrise R / L
- /__ / Leg Length R / L
- /__ / Os Calsis/Heel R / L
- /__ / Patella R / L
- /__ / Pelvis AP/Inlet/Outlet R / L
- /__ / Sacroiliac Joints R / L
- /__ / Sacrum - Coccyx
- /__ / Scapula R / L
- /__ / Shoulder AP R / L
- /__ / Shoulder Complete R / L
- /__ / Sternum
- /__ / Tibia AP/Lat R / L
- /__ / Tibia AP/Lat/Obliques R / L
- /__ / Toe or Toes R / L
- /__ / Wrist AP/Lat R / L
- /__ / Wrist AP/Lat/Obliques R / L
- /__ / X-Ray Copies

Other: _____

Area of Interest: _____

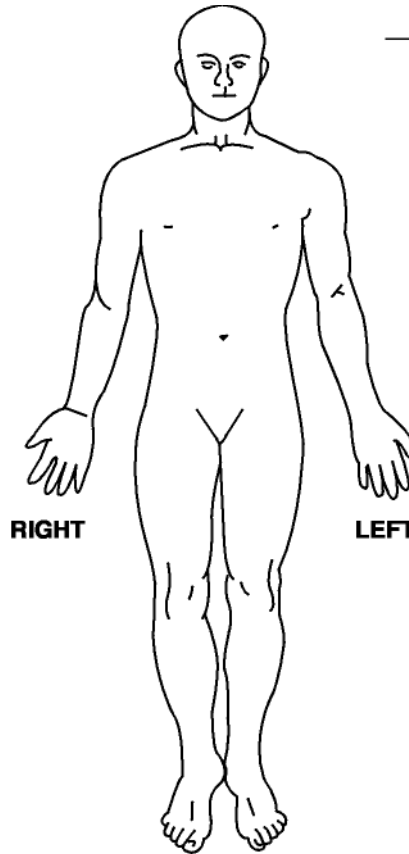
Diagnosis: _____

Reason for Exam: _____

Physician Signature: _____, M.D.

DATE/TIME

Date



FRONT

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**SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HOSPITAL & CLINICS**

Miami, FL 33136 www.med.miami.edu (305)243-1000

ORTHOPAEDICS DOCTOR'S ORDERS

NAME: _____

UMMG # MRN

AGE: _____ DOB: _____ / _____ / _____

DATE OF SERVICE: _____



Form
A1400013

Revised
05/10/05