



FDNY BUREAU OF HEALTH SERVICES
CANDIDATE RADIOLOGY REFERRAL - BHS FORM 5

Do Not Write In this Box - For BHS Use Only
ACCESSION NO: _____
ID NO: _____

CANDIDATE INFORMATION

Name (Last, First):	Last Four Digits of Social Security:	Date of Birth (MM/DD/YYYY):	Civil Service Title:

RADIOLOGY REFERRAL

INSTRUCTIONS

Candidates for employment must be administered a Chest X-Ray and any other X-Ray(s), as required by the Bureau of Health Services. If you are pregnant, think you may be pregnant, or are trying to become pregnant, please inform the X-Ray technologist.

I have read and understand the foregoing instructions.

CANDIDATE SIGNATURE: _____

DATE: _____

(Candidates Shall Not Write Below This Line - To Be Completed by FDNY - Bureau of Health Services Personnel Only)

REASON FOR CHEST X-RAY: Candidate Evaluation ADDITIONAL X-RAY(S) REQUESTED: YES NO

ADDITIONAL X-RAY(S) REQUESTED BY: _____

X-RAY(S) REQUESTED (CHECK ALL ITEMS THAT APPLY):

- | | | |
|--|---|--|
| <input type="checkbox"/> CHEST - PA | <input type="checkbox"/> SPINE - CERVICAL/ROUT | <input type="checkbox"/> EXTREMETIES - UPPER |
| <input type="checkbox"/> CHEST - PA/LAT | <input type="checkbox"/> SPINE - CERVICAL/OBL | <input type="checkbox"/> HUMERUS - R - L |
| <input type="checkbox"/> RIBS - R - L | <input type="checkbox"/> SPINE - DORSAL | <input type="checkbox"/> ELBOW - R - L |
| <input type="checkbox"/> SHOULDER - R - L | <input type="checkbox"/> SPINE - LUMBOSACRAL/ROUT | <input type="checkbox"/> FOREARM - R - L |
| <input type="checkbox"/> SCAPULA - R - L | <input type="checkbox"/> SPINE - LUMBOSACRAL/OBL | <input type="checkbox"/> WRIST - R - L |
| <input type="checkbox"/> CLAVICLE - R - L | <input type="checkbox"/> SPINE - ENTIRE | <input type="checkbox"/> HAND - R - L |
| <input type="checkbox"/> ACROMIO-CLAVICULAR | <input type="checkbox"/> PELVIS | <input type="checkbox"/> FINGER - R - L |
| <input type="checkbox"/> STERNUM | <input type="checkbox"/> HIP - R - L | <input type="checkbox"/> EXTREMETIES - LOWER |
| <input type="checkbox"/> SKULL | <input type="checkbox"/> SACRUM | <input type="checkbox"/> FEMUR - R - L |
| <input type="checkbox"/> FACIAL BONES | <input type="checkbox"/> COCCYX | <input type="checkbox"/> KNEE - R - L |
| <input type="checkbox"/> NASAL BONES | <input type="checkbox"/> ABDOMEN PLAIN | <input type="checkbox"/> LEG (TIB/FIB) - R - L |
| <input type="checkbox"/> SINUSES | <input type="checkbox"/> ABDOMEN - ERECT / SUPINE | <input type="checkbox"/> ANKLE - R - L |
| <input type="checkbox"/> MANDIBLE | <input type="checkbox"/> OTHER: | <input type="checkbox"/> FOOT - R - L |
| <input type="checkbox"/> ORBITS | _____ | <input type="checkbox"/> TOE - R - L |
| <input type="checkbox"/> TEMPORAL MANDIBULAR | _____ | <input type="checkbox"/> HEEL - R - L |
| <input type="checkbox"/> SELLA TURCICA | _____ | |

TECHNOLOGIST SIGNATURE:	DATE: