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)

SAMPLE

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)

- ☐ CHEST - PA
- ☐ CHEST – PA/LAT
- ☐ RIBS – R - L
- ☐ SHOULDER – R - L
- ☐ SCAPULA – R - L
- ☐ CLAVICLE – R – L
- ☐ ACROMIO-CLAVICULAR
- ☐ STERNUM
- ☐ SKULL
- ☐ FACIAL BONES
- ☐ NASAL BONES
- ☐ SINUSES
- ☐ MANDIBLE
- ☐ ORBITS
- ☐ TEMPORAL MANDIBULAR
- ☐ SELLA TURCICA

- ☐ SPINE – CERVICAL/ROUT
- ☐ SPINE – CERVICAL/OBL
- ☐ SPINE - DORSAL
- ☐ SPINE – LUMBOSACRAL/ROUT
- ☐ SPINE – LUMBOSACRAL/OBL
- ☐ SPINE - ENTIRE
- ☐ PELVIS
- ☐ HIP – R - L
- ☐ SACRUM
- ☐ COCCYX
- ☐ ABDOMEN PLAIN
- ☐ ABDOMEN – ERECT / SUPINE
- ☐ OTHER:

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EXTREMETIES - UPPER

- ☐ HUMERUS – R - L
- ☐ ELBOW – R - L
- ☐ FOREARM – R - L
- ☐ WRIST – R – L
- ☐ HAND – R - L
- ☐ FINGER – R - L

EXTREMETIES - LOWER

- ☐ FEMUR – R - L
- ☐ KNEE – R - L
- ☐ LEG (TIB/FIB) – R - L
- ☐ ANKLE – R – L
- ☐ FOOT – R – L
- ☐ TOE – R – L
- ☐ HEEL – R – L

TECHNOLOGIST SIGNATURE:	**DATE:**