New Mexico Physical Therapy Imaging Referral Form

Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Address: _____

Referring Physical Therapist

Referring PT: _____

License Number: _____

Clinic/Facility: _____

Phone: _____

Fax: _____

Email: _____

Preferred Report Delivery: ☐ Fax ☐ Phone ☐ Secure Email

Imaging Study Requested

Category	Options (Check all that apply)
X-ray	☐ C-Spine ☐ T-Spine ☐ L-Spine ☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Pelvis ☐ Ribs ☐ Other: _____
MRI	☐ C-Spine ☐ T-Spine ☐ L-Spine ☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Brain (non-contrast unless indicated) ☐ Other: _____
CT	☐ C-Spine ☐ T-Spine ☐ L-Spine ☐ Extremity: _____ ☐ Other: _____

Provided for you by Adam Walsh, PT, DPT, Beth Moody Jones, PT, DPT, EdD and The University of New Mexico Division of Physical Therapy

Clinical Information

Clinical Indication(s)

Primary Complaint: _____

Clinical Findings: _____

_____

Duration of Symptoms: _____

Functional Limitations: _____

Urgency ☐ Routine ☐ Urgent (24–48 hrs) ☐ STAT

If STAT, reason: _____

_____

Prior Imaging

☐ Patient will bring prior images/CD

☐ Prior imaging available at: _____

Notes for Radiologist

_____

_____

Therapist Signature _____

Therapist Name (Printed) _____

Date _____

Please fax or securely transmit the final radiology report to the referring physical therapist listed above.

This form is intended for use by licensed doctors of physical therapy in New Mexico authorized to order diagnostic imaging under current state law.

Provided for you by Adam Walsh, PT, DPT, Beth Moody Jones, PT, DPT, EdD and The University of New Mexico Division of Physical Therapy