CFL DIAGNOSTIC

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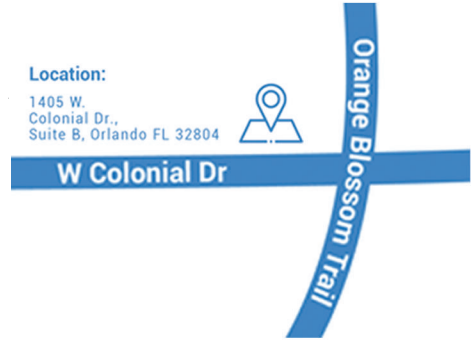
(407) 749-6118

☐ Auto
☐ Other_____

Patient Name_____ Practice Name_____
Date of Birth_____ Practice Address_____
Date of Accident_____ Physician Tel_____
Patient Tel_____ Physician Fax_____
Insurance_____ Physician Email_____
Policy Number_____ Attorney Name_____
Claim Number_____ Attorney Tel_____
Diagnosis_____
Physician Name_____ Physician Signature_____ Date_____
Notes_____



☐ **Schedule patient for an EMC Evalutation, as defined by Florida statutes sections 627.730-627.7405.**

MRI ☐ Without Contrast ☐ With & Without Contrast

☐ C-Spine ☐ W/SWI ☐ Shoulder L/R ☐ Knee L/R
☐ T-Spine ☐ Soft Tissue Neck ☐ Elbow L/R ☐ Ankle L/R
☐ L-Spine ☐ Brachial Plexus ☐ Wrist L/R ☐ Foot L/R
☐ Brain ☐ Chest ☐ Hand L/R
☐ IAC's ☐ Abdomen ☐ Hip L/R
☐ Orbits ☐ Pituitary ☐ Pelvis L/R

X-RAY

☐ C-Spine ☐ Skull ☐ Shoulder L/R ☐ Knee L/R
☐ T-Spine ☐ IAC's ☐ Elbow L/R ☐ Ankle L/R
☐ L-Spine ☐ Orbits ☐ Wrist L/R ☐ Foot L/R
☐ W/SWI ☐ Hand L/R
☐ Chest ☐ Hip L/R
☐ Abdomen ☐ Pelvis L/R

☐ Other_____