



DIAGNOSTIC IMAGING NETWORK

Referral Form

Patient Name: _____ Phone: _____

Provider: _____ Phone: _____

Examination Requested: _____

Clinical Impression / Diagnosis: _____

Provider's Signature: _____ Date: _____

** Please check the desired location below**

SHERMAN OAKS

4910 Van Nuys Blvd. #108
Sherman Oaks, CA 91403
Tel: (818) 986-8215
Fax: (818) 986-9582



- ◆ CT Scan
- ◆ DEXA / Bone Density
- ◆ Mammography
- ◆ MRI - Upright / Positional
- ◆ MR - Arthrogram
- ◆ Ultrasound / Transvaginal
- ◆ X-RAY - Skeletal

GLENDALE-CENTRAL

800 S. Central Ave. #100B
Glendale, CA 91204
Tel: (818) 548-8333
Fax: (818) 548-7888



- ◆ DEXA / Bone Density
- ◆ Cardiac Echo
- ◆ Digital Mammography
- ◆ MRI - 1.5T
- ◆ MRA
- ◆ Ultrasound / Transvaginal
- ◆ US Guided Biopsy
- ◆ X-RAY - Skeletal

GLENDALE-PET/CT

403 S. Glendale Ave.
Glendale, CA 91205
Tel: (818) 546-1929
Fax: (818) 546-1930



- ◆ CT Scan
- ◆ CT-Angiography
- ◆ PET
- ◆ PET/CT
- ◆ PET - Bone Scan

BEVERLY HILLS

8641 Wilshire Blvd. #105
Beverly Hills, CA 90211
Tel: (310) 919-3330
Fax: (310) 854-1860



- ◆ MRI - 1.5T
- ◆ X-RAY - Skeletal

VAN NUYS

13311 Victory Blvd.
Van Nuys, CA 91403
Tel: (747) 777-8494
Fax: (747) 264-1142



- ◆ Open MRI

ONLY FOR PERSONAL INJURY REFERRAL

Date of Injury: _____

Name of Attorney: _____ Phone: _____