

Radiology Troubleshooting

Chiropractor Name: _____

Date of Original Request: _____

Patient Name: _____

Patient Health Card #: _____

Patient Date of Birth: _____

Zone the X Ray was done in: _____

Type of Request: ☐ Copy of images from a previous DI request

☐ New request

Comments (Please include responses and/emails as well as list the steps you have taken)

Please email a copy of the form you submitted for your original request and any additional correspondence related to this issue.