MOBILE IMAGING SOLUTIONS Referral Form

MOBILE Imaging SOLUTIONS

PROFESSIONAL TIMELY ACCURATE

Phone: 214-738-2771
Fax: 866-485-1369
Email:
herschel@mobileimagingsolutions.com

Date of exam __/__/____ Fax/Email results to _____

Facility Name _____ Room #_____

Address _____ PH#_____

Patient Name _____ DOB __/__/____ male/female

SS#___-__-____ Medicare # _____ Insurance Co # _____ Auth # _____

Ordering Physician (Last)_____(First)_____ NPI # _____

Portable : X-RAY___ EKG___ Special Instructions

Pt is HOMEBOUND _____ SNF_____ OTHER_____ _Patient condition requires mobile/portable exam.____

X-RAY EXAMS

BODY

__74018 Abdomen 1 View
__74019 Abdomen 2 View
__73502 Pelvis &Hip 2 Views L or R
__73523 Hips Bilateral,w/AP Pelvis

UPPER EXTREMITIES

Please circle L or R if applicable.

__73000 Clavical L or R
__73030 Shoulder L or R
__73010 Scapula L or R
__73060 Humerus 2 Views L or R
__73080 Elbow 3 Views L or R
__73090 Forearm 2 Views L or R
__73110 Wrist Complete L or R
__73130 Hand 3 Views L or R
__73140 Fingers 2 Views L or R
1 2 3 4 5

CHEST

__71045 Chest 1 View
__71046 Chest 2 View
__71100 Ribs 2 View L or R
__71110 Ribs Bilateral 3 Views

X-RAY EXAMS

LOWER EXTREMITIES

__73552 Femur 2 Views L or R
__73562 Knee 3 Views L or R

__73590 Tib/Fib 2 Views L or R
__73610 Ankle 3 Views L or R
__73650 Calcaneus 2 Views L or R
__73660 Toes 2 Views L or R
1 2 3 4 5
__73620 Foot 2 Views L or R
__73630 Foot Complete L or R

SPINE

__72040 C- Spine
__72070 T- Spine 2 Views
__72100 L- Spine 2-3V iews
__72220 Sacrum/Coccyx

Other

X-RAY EXAMS

Head and Neck

__70150 Facial Bones Complete
__70100 Mandible Complete
__70160 Nasal Bones Complete
__70220 Sinuses Complete
__70260 Skull Complete

Diagnosis Chest/Ribs	Diagnosis Abdomen	Diagnosis Skeletal
__Abn Chest Sounds	__Distention	__Contusion Lower
__Congestion	__Rigidity	__Contusion Upper
__CHF	__Abn Bowel Sounds	__Edema
__Collapsed Lung	__Constipation	__Fall
__COPD	__Diarrhea	__Pain
__Cough	__Intestinal Obstr	__Strain
__Pain	__Nausea	__Other
__Pneumonia	__Nausea & Vomiting	If Other Please Specify Below.
__Positive PPD	__Pain	
__SOB	__Tube Placement	
__Fever	__Vomiting	
__PICC Placement		
__Tightness/Discomfort		

The individual signing below is verifying the presence of a written Physician's order for the exam being performed on the patient named above. Signature is required by one of the following.

TITLE: RN__ LVN__ MD__ DO__ NP__ PA__

SIGNATURE_____