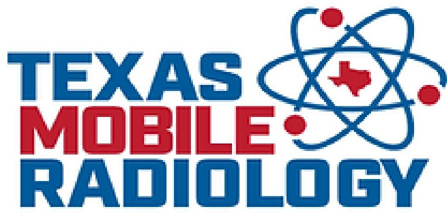

Professional Timely Accurate

Referral Form

844-321-XRAY(9729)
Fax: 512-233-5966
mobileimaging@outlook.com

Date of Exam:_____________ Fax/Email results to: ____

Facility Name:______________________ Rm#________ Facility Ph#_____________________________

Pt Address: ____ Pt Ph#:___________________________

Patient Name: ____ DOB :_____________ Male/Female

SS# ___________ Medicare #___________________ Insurance Co # _______________ Auth # _____________

Ordering Physician (Last) ________________(First) ____________ NPI# _________________________

Portable Exam Required: X-Ray__ EKG:___ US:___ Special Instructions: ____________________________

Pt is HOMEBOUND__ SNF__ ALF__ MemCare__

Provider requires portable imaging examination due to increased risk factors toward patient condition during transport, safety, or site access to care ✓

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 Clavicle 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 Exam(s) or Instructions

PORTABLE ONSITE EXAM REQUIRED. PATIENT SAFETY RISKS INCLUDE:

POOR PHYSICAL CONDITION
ALZIEMHERS / DEMENTIA
REDUCED OR ALTERED MENTAL STATUS
INCREASED RISK OF INJURY TO TRANSPORT
PT IS UNDER THE CARE OF SNF/ALF/REHAB
OTHER; PLEASE DESCRIBE BELOW

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		

SIGNER VERIFIES THE MEDICAL NECESSITY AND REQUIREMENT FOR PORTABLE EXAM PERFORMANCE. SIGNATURE CONFIRMS PRESENCE OF PROVIDER'S WRITTEN ORDER FOR THE PORTABLE EXAM REQUESTED. WRITTEN or E-SIGNATURE REQUIRED BELOW. If signed by the provider, this referral form becomes an acceptable provider order.

SIGNATURE:_____________________________