



Referral Form

844-321-XRAY(9729)

Fax: 512-233-5966

mobileimaging@outlook.com

Professional Timely Accurate

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 2-3 Views
 ___ 72220 Sacrum/Coccyx

Other Exam(s) or Instructions

PORTABLE ONSITE EXAM REQUIRED. PATIENT SAFETY RISKS INCLUDE:

POOR PHYSICAL CONDITION
 ALZHEIMER'S DISEASE / 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: _____