MEDICAL IMAGING SPECIALISTS

Phone. **708-634-2929** / Fax. **708-634-2945**
9944 S Robert Rd, Suite 106, Palos Hills, IL 60465

Name: _____ Date: _____

Date of Birth: _____ Sex: ❑ M ❑ F Medicare: _____

S.S. No: _____ Medicaid: _____

Facility: _____

Room No: _____ Bed No: _____

Tel: _____ Fax: _____

Physician's Name: _____

Physician's Signature: _____

NPI No: _____

Nurse Name: _____

Commerical Insurance, HMO / PPO:

Policy: _____

Group: _____

Financial Power of Attorney:

Name: _____

City: _____ State: _____ Zip Code: _____

Tel: _____ (Home) _____ (Cell) _____

Date: _____

I acknowledge that the Physician's Order and medical necessity for the exam ordered below is documented in the patient's chart.
A portable X-Ray / IDTF procedure is being ordered since this patient would find it physically and/or psychologically taxing because of advanced age and physical limitation, to receive an X-Ray / IDTF procedure outside this home. This test is determined necessary for the diagnosis and treatment of this patient.

CLINICAL INFORMATION: (SYMPTOMS MUST BE INDICATED FOR MEDICARE COVERAGE) _____

REASON(S) FOR PORTABLE X-RAY / ULTRASOUND (Indications and/or medical necessity): _____

X-RAY PROCEDURES

T. Tube Yes ..... No

CHEST
- ❑ AP ONLY
- ❑ CHEST AP&LAT

RIBS
- ❑ RIGHT RIBS ❑ LEFT RIBS

SKULL
- ❑ SKULL SERIES
- ❑ FACIAL BONES
- ❑ ORBIT VIEWS
- ❑ MANDIBLE
- ❑ SINUS SERIES
- ❑ NASAL BONES

SPINE / PELVIS
- ❑ CERVICAL SPINE
- ❑ DORSAL SPINE (T-SPINE)
- ❑ LUMBAR SPINE
- ❑ SACRUM & COCCYX
- ❑ PELVIS
- ❑ ABD-KUB (X-RAY)

SKELETAL SYSTEM
- ❑ R - L SCAPULA
- ❑ R - L CLAVICLE
- ❑ R - L SHOULDER
- ❑ R - L HUMBERUS
- ❑ R - L ELBOW
- ❑ R - L FOREARM
- ❑ R - L WRIST
- ❑ R - L HIP
- ❑ R - L FEMUR
- ❑ R - L KNEE
- ❑ R - L TIBIA & FIBULA
- ❑ R - L ANKLE
- ❑ R - L FOOT
- ❑ R - L CALCANEUS

OFFICIAL USE ONLY
CHART NO: _____
DATE BILLED: _____
BILLED BY: _____

ULTRASOUND
- ❑ ABDOMINAL COMPLETE (U/S)
- ❑ RENAL (KIDNEY) COMPLETE
- ❑ OB COMPLETE
- ❑ PELVIS NON-OB COMPLETE
- ❑ SCROTUM
- ❑ THYROID
- ❑ BREAST
- ❑ TRANSABDOMINAL PROSTATE

CARDIOVASCULAR STUDIES
- ❑ CAROTID DOPPLER
- ❑ ECHOCARDIOGRAM / HEART ULTRASOUND
- ❑ ARTERIAL DOPPLER - ARMS ❑ R ❑ L / LEGS ❑ R ❑ L
- ❑ VENOUS DOPPLER - ARMS ❑ R ❑ L / LEGS ❑ R ❑ L

OTHERS: (Procedure(s) or View(s))

Please Specify: _____

❑ EKG - 12 LEAD

REGISTERED TECHNICIAN SECTION

TIME PROCEDURE(S) COMPLETED: _____

SIGNATURE: _____ DATE: _____

PREGNANCY DISCLAIMER: To the best of my knowledge, I am not currently pregnant and authorize Medical Imaging Specialists, Inc. to perform X-Ray / IDTF procedure(s). I understand that: exposure to x-rays can be harmful to an unborn fetus. **Patient's Signature:** _____ **Date:** _____