

Patient Name: \_\_\_\_\_ DATE OF SERVICE: \_\_\_\_\_  
First Middle Initial Last

AM | P.M.

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Departure Time: \_\_\_\_\_

Physician: \_\_\_\_\_ Fax: \_\_\_\_\_

Insurance Information:  
Medicare Number: \_\_\_\_\_

Facility: \_\_\_\_\_ Fax: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ State \_\_\_\_\_

Room#: \_\_\_\_\_ Station: \_\_\_\_\_ Male:  Female:

Co/Other Insurance: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Policy#: \_\_\_\_\_

Address: \_\_\_\_\_

Group #: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Other info: \_\_\_\_\_

**Check Desired Service With ICD9 CODE OR WRITE:**

**Head and Neck:**

- 70260 Skull 4 views
- 70210 Sinuses less than 3 view
- 70110 Mandible
- 70150 Facial Bones Complete
- 70140 Facial Bones 2 views
- 70160 Nasal Bones
- 70200 Orbits
- 70140 Maxilla
- 70360 Soft tissue Neck

**Gastro-Urological:**

- 74000 Abdomen 1 View
- 74020 Abdomen 2 View

**Upper Extremity: Circle One**

- 73010 Scapula R | L
- 73030 Shoulder R | L
- 73000 Clavicle R | L
- 73090 Forearm R | L
- 73080 Elbow 3+views R | L
- 73110 Wrist 3+views R | L
- 73130 Hand 3 views R | L
- 73060 Humerus R | L

**Lower Extremity:**

- 73500 Hip 1 view R | L
- 73510 Hip 2 Views R | L
- 73520 Hip Bilateral R | L
- 73550 Femur R | L
- 73564 Knee 4 view R | L
- 73590 Tibia/Fibula R | L
- 73610 Ankle 3 view R | L
- 73630 Foot 3 view R | L
- 73650 Heel/calcaneus R | L

**Spine:**

- 72050 Cervical 4 view
- 72070 Thoracic spine 2 view
- 72100 Lumbar Spine 2/3views
- 72220 Sacrum/Coccyx
- 72170 Pelvis 1/2 views

**Symptom ICD9-Codes:**

- 786.05 Shortness of Breath
- 786.09 Respiratory Distress
- 496 C.O.P.D.
- 786.2 Cough
- 507.0 Aspiration
- 795.5 Positive PPD
- 789.00 Abdominal/Pelvic Pain
- 719.45 Hip Pain
- 724.5 Back Pain
- 729.5 Limb Pain
- E888 S/P Fall
- 785.2 Murmur
- 428.0 C.H.F.
- 427.31 Atrial Fibrillation
- 427.9 Irregular Heart Beat
- 443.9 PVD
- 780.2 Syncope
- 440.20 Atherosclerosis LE
- 729.81 Limb Swelling/Edema
- 586 Renal Failure
- 790.5 Elevated LFT
- 787.03 Vomiting
- 780.6 Fever
- Other: \_\_\_\_\_

**Chest:**

- 74022 Acute Abd with Chest
- 71010 Chest 1 view
- 71020 Chest 2 Views
- 71101 Ribs Unilat with CXR
- 71111 Ribs Bilateral
- 71120 Sternum

**Interventional:**

- 36569 PICC placement
- 76937 Ultrasound Guidance
- V58.81 CXR Verify PICC
- Location

**Ultrasound:**

- 76645 Breast Ultrasound
- 93971 Venous Doppler Unilat
- 93970 Venous Doppler Bilat
- 76700 Abdominal
- 76770 Retroperitoneal
- 76536 Thyroid/Neck
- 93325|93320|93307 Echocardiogram (2d)
- 76870(93975) Scrotum/testicle
- 76856 Pelvic US/76805 OB US
- 93922Ankle/Brachial Index
- 93925 Arterial Doppler Bilat
- 93880Carotid Doppler
- 93923 Segmental Pressures
- Lower ext.

**Electrocardiogram:**

- 93005EKG (ECG)
- 93231/93232 Holter Monitor

I ACKNOWLEDGE THE ORDERING PHYSICIAN'S SIGNED ORDERS ARE ON THE FILE AT THIS FACILITY.

DATE: \_\_\_\_\_  
NURSE'S SIGNATURE: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS/OR ANY CLAIM FOR ANY INSURANCE CARRIER, INCLUDING MEDICARE, MEDICAID, BLUE CROSS/BLUE SHIELD. I AUTHORIZE PAYMENT TO ALL SERVICES THAT ARE NECESSARY TO COMPLETE THIS ASSIGNMENT, SUCH AS RADIOLOGICAL AND PRIVATE PHYSICIANS IN ANY SPECIALTY. I WILL ASSUME FINANCIAL RESPONSIBILITY FOR THIS SERVICE IF PAYMENT IS DENIED BY INSURANCE COMPANY AS ROUTINE OR NOT MEDICALLY REASONABLE AND NECESSARY.

I CHECK HERE IF PATIENT UNABLE TO SIGN. PATIENT RECEIVED THE ORDERED EXAM(S).  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ORDERING PHYSICIAN OR AUTHORIZED REPRESENTATIVE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**For official use only**

Procedure	Procedure code	Fee	Diagnosis

Tech: \_\_\_\_\_ Facility Called: \_\_\_\_\_ Time \_\_\_\_\_  
 Reading Service: \_\_\_\_\_ Doctor Called: \_\_\_\_\_ Time \_\_\_\_\_  
 Date: \_\_\_\_\_ Radiologist \_\_\_\_\_