



Home Health Radiology Services

View X-rays and Reports
<http://portableservice.com>

Tel: (888) 964-0088
Fax: (866) 498-0867

P.O. Box 2092
Union, NJ 07033

In Affiliation with On-Site Imaging; Ultrasound

X-RAY, ULTRASOUND & EKG REQUEST FORM

PLEASE PRINT CLEARLY

M F Date Requested: _____ Date Complete: _____

Patient's Name: _____ SS#: _____

Street: _____ Phone: _____

City, State, Zip: _____

Medicare #: _____ Sec. Ins. _____ Date of Birth: _____ Age: _____

Facility: _____ Tel: _____ Fax: _____

Primary Physician ONLY: _____ NPI#: _____

Address: _____ Tel: _____ Fax: _____

X-RAYS & EKG

Please check the specific part of the body to be examined:

CHEST	CODE	LOWER EXTREMITIES	CODE	UPPER EXTREMITIES	CODE
<input type="checkbox"/> CHEST AP ONLY	71010	<input type="checkbox"/> BILATERAL HIP	73520	<input type="checkbox"/> CLAVICLE	L R 73000
<input type="checkbox"/> CHEST AP & LAT	71020	<input type="checkbox"/> HIP	L R 73510	<input type="checkbox"/> SCAPULA	L R 73010
<input type="checkbox"/> CHEST LORDOTIC	71021	<input type="checkbox"/> FEMUR	L R 73550	<input type="checkbox"/> SHOULDER	L R 73030
<input type="checkbox"/> RIBS UNILATERAL L R	71101	<input type="checkbox"/> KNEE AP&LAT	L R 73560	<input type="checkbox"/> HUMERUS	L R 73060
<input type="checkbox"/> RIBS BILATERAL	71111	<input type="checkbox"/> TIBIA & FIBULA	L R 73590	<input type="checkbox"/> ELBOW COMP.	L R 73080
<input type="checkbox"/> STERNUM	71130	<input type="checkbox"/> ANKLE, COMPLETE	L R 73610	<input type="checkbox"/> FOREARM	L R 73090
		<input type="checkbox"/> FOOT, COMPLETE	L R 73630	<input type="checkbox"/> WRIST, COMP.	L R 73110
		<input type="checkbox"/> HEEL	L R 73650	<input type="checkbox"/> HAND, COMP.	L R 73130
		<input type="checkbox"/> TOES	L R 73660	<input type="checkbox"/> FINGER	L R 73140

HEAD & NECK	CODE	SPINE & PELVIS	CODE	ABDOMEN	CODE	CARDIOLOGY	CODE
<input type="checkbox"/> NASAL BONES	70160	<input type="checkbox"/> THORACIC	72070	<input type="checkbox"/> KUB	74000	<input type="checkbox"/> EKG	93000
<input type="checkbox"/> SINUSES	70220	<input type="checkbox"/> CERVICAL 2V	72050	<input type="checkbox"/> OBSTRUCTIVE SERIES	74022	<input type="checkbox"/> LONG RHYTHM	93000
<input type="checkbox"/> SKULL	70260	<input type="checkbox"/> LUMBAR 2V	72100			<input type="checkbox"/> HOLTER	93230
<input type="checkbox"/> FACIAL BONE	70150	<input type="checkbox"/> LUMBAR 4V	72110			<input type="checkbox"/> PACEMAKER CHECK	
<input type="checkbox"/> ORBIT	70200	<input type="checkbox"/> PELVIS	72170				
<input type="checkbox"/> MANDIBLE	70100	<input type="checkbox"/> SACROILIAC	72202				
		<input type="checkbox"/> SACRUM & COCCYX	72220				

DIAGNOSIS: _____

ULTRASOUND

FAX ULTRASOUND REQUEST TO On-Site Imaging at 732-718-3003 OR CALL 732-333-3906

VENOUS DUPLEX W/ DOPPLER	ARTERIAL DUPLEX W/ DOPPLER	ABDOMINAL SURVEY
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RT LEG LT LEG BOTH
 RT ARM LT ARM BOTH

RT LEG LT LEG BOTH
 RT ARM LT ARM BOTH

COMPLETE ABDOMINAL
SPECIAL ATTENTION: _____
 AORTA DUPLEX
 RENAL BLADDER KUB
 RENAL ARTERY

SMALL PARTS	CAROTID DUPLEX	ECHOCARDIOGRAPHY
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PELVIC SCROTUM
 THYROID PROSTATE

CAROTID

ECHO 2D M-MODE W/CARDIAC DOPPLER AND COLOR FLOW

ULTRASOUND EXAM PREPARATIONS

- ABDOMINAL SURVEY: OK TO DRINK WATER. NO EATING FOR 4-6 HOURS PRIOR TO EXAM
- PELVIC/BLADDER: DRINK 4-5 GLASSES OF WATER PRIOR TO EXAM (EVEN IF ORDERED W/ABDOMINAL U/S)

DIAGNOSIS: _____