UNITED DIAGNOSTIC SERVICES, LLC.

6124 N. Milwaukee Ave., Suite # 2 Chicago, IL 60646
Phone: 773-774-8100 Fax: 773-774-8101 | www.unitedxray.com

Please Print

Name: _____ Date: ☐☐ ☐☐ ☐☐

Last First

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

S S N: ☐☐☐ ☐☐ ☐☐☐☐ Medicaid: ☐☐☐ ☐☐☐ ☐☐☐

Facility: _____

Room No: _____ Bed No: _____

Tel: _____ Fax: _____

Physician's Name: _____

Physician's Signature: _____

NPI No: _____

Commercial Insurance. HMO / PPO:

Policy: _____

Group: _____

Financial Power of Attorney:

Name: _____

City: _____ State: ____ Zip Code: _____

Tel: _____ (Home) _____ (Cell)

Nurse's Name: _____ **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 / or physical limitations, to receive an X-Ray / IDTF procedure outside their home. This test is deemed 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

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 HUMERUS
❑ R - L ELBOW
❑ R - L FOREARM
❑ R - L WRIST
❑ R - L HAND
❑ R - L HIP
❑ R - L FEMUR
❑ R - L KNEE
❑ R - L TIBIA & FIBULA
❑ R - L ANKLE
❑ R - L FOOT
❑ R - L CALCANEUS

OTHER: (Procedure(s) or View(s))

Please Specify _____

ULTRASOUND

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

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

❑ 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 United Diagnostic Services, 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:

* To order Portable Diagnostic Services, requestor must provide us the Prescribing Physician's Signed Order by Fax or Mail.