Life Care Imaging
7400 Waukegan Rd, Suite # 107, Niles, IL 60714
Tel: (800) 919-1761 Fax: (800) 919-1761
www.lifecareimaging.com

Please Print

Name: _____ Date: __ __ __ __ __ __

Last: First:

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: _____

Commercial Insurance. HMO / PPO:

Policy: _____

Group: _____

Financial Power of Attorney:

Name: _____

City: _____ State: _____ ZipCode: _____

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 limitations, to receive an X-Ray / IDTF procedure outside is bome. This test is determined for the diagnosis and treatment of this patient.

CLINICAL INFORMATION: (SYMPTOMS MUST BE INDICATED FOR MEDICAL COVERAGE) _____
REASON(S) FOR PORTABLE X-RAY / ULTRASOUND (indication and/or medical necessity): _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- ❑ Abdominal KUB 1 View 74018
- ❑ Abdominal Flat & Upright 2 View 74020
- ❑ Chest 1 View 71045
- ❑ Chest AP / LAT 71046
- ❑ Ribs 2 View ..... ❑(R) .....❑(L) 71100
- ❑ Ribs UNILATERAL + PA Chest 3 View 71101
- ❑ Ribs BILATERAL + PA Chest 4 View 71111

HEAD AND NECK

- ❑ Skull 70250
- ❑ Facial Bones 3 View 70150
- ❑ Orbits 4 View 70200
- ❑ Nasal Bones 3 View 70160
- ❑ Mandible ..... ❑(R) .....❑(L) 70100
- ❑ Sinuses 70210

UPPER EXTREMITIES

- ❑ Clavicle 2 View ..... ❑(R) .....❑(L) 73000
- ❑ Scapula 2 View ..... ❑(R) .....❑(L) 73010
- ❑ Shoulder 2 View ..... ❑(R) .....❑(L) 73030
- ❑ Humerus 2 View ..... ❑(R) .....❑(L) 73060
- ❑ Elbow 3 View ..... ❑(R) .....❑(L) 73080
- ❑ Forearm 2 View ..... ❑(R) .....❑(L) 73090
- ❑ Wrist 3 View ..... ❑(R) .....❑(L) 73110
- ❑ Hand 3 View ..... ❑(R) .....❑(L) 73130
- ❑ Fingers 2 View ..... ❑(R) .....❑(L) 73140

SPINE AND PELVIS

- ❑ Cervical Spine AP /LAT 72040
- ❑ Thoracic Spine 3 View 72072
- ❑ Lumbar Spine 2-3 View 72100
- ❑ Pelvis 1-2 View 72170
- ❑ Sacrum Coccyx 72220

LOWER EXTREMITIES

- ❑ HIP BILATERAL 4 View 73520
- ❑ HIP AP /LAT ..... ❑(R) .....❑(L) 73501
- ❑ Femur 2 View ..... ❑(R) .....❑(L) 73550
- ❑ Knee 1-2 View ..... ❑(R) .....❑(L) 73560
- ❑ Knee 3 View ..... ❑(R) .....❑(L) 73562
- ❑ Tibia / Fibula 2 View ❑(R) .....❑(L) 73590
- ❑ Ankle 3 View ..... ❑(R) .....❑(L) 73610
- ❑ Foot 3 View ..... ❑(R) .....❑(L) 73630
- ❑ Heel 2 View ..... ❑(R) .....❑(L) 73650
- ❑ Toes 2 View ..... ❑(R) .....❑(L) 73660

❑ Other _____

Reason for study: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule out DVT ❑)

- ❑ Venous Upper (Bilat) ❑(R) .....❑(L) 93970/93971
- ❑ Venous Lower (Bilat) ❑(R) .....❑(L) 93970/93971
- ❑ Arterial Upper (Bilat) ❑(R) .....❑(L) 93930/93931
- ❑ Arterial Lower (Bilat) ❑(R) .....❑(L) 93925/93926
- ❑ Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- ❑ Complete Abdominal * 76770
- ❑ AORTA / AAA 76706
- ❑ Renal 76770
- ❑ Bladder ** 76857

Pelvic

- ❑ Pelvic **..... 76856
- ❑ Pelvic Non-OB ** 76856
- ❑ Testicular / Scrotum 76870
- ❑ Soft Tissue Groin 76882

Head and Neck

- ❑ Thyroid 76536
- ❑ Neck Soft tissue 76536
- ❑ Carotid Duplex Doppler 93880

Breast

- ❑ Breast (Bilat)..... ❑(R) .....❑(L) 76642/76641

❑ Other _____

* Abdominal Ultrasounds require patient not eat or drink at least 6 Hours prior ro exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

Reason for study: _____

CARDIAC STUDIES:

- ❑ EKG 93000
- ❑ Holter Monitor 24 HR 93228
- ❑ Echocardiogram 93306
- ❑ Pacemaker check 93293

PREGNANCY DISCLAIMER: To the best of my knowledge, I am not currently pregnant and authorize LifeCare Imaging, 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 st provide us the Prescribing Physician's Signed Order by Fax (or) Mail.