D-RAD MOBILE IMAGING

"LOYALTY AND CONSISTENCY, 24/7

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Appt. Date: ______________

Appt. Time: ______________

☐ Please call my patient and schedule

Fax to D-Rad

Patient Name:______________________________ Date of Birth:______________ Cell ______________

Physician (print):______________________________ O Routine O Stat (cell) ______________(required)

Physician Signature:______________________________ **Diagnoses:**_______ _______ _______ _______

NPI No.______________________________ Physicians Order______________________________

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THIS PATIENT WOULD FIND IT PHYSICALLY AND/OR PSYCHOLOGICALLY TAXING, BECAUSE OF ADVANCED AGE AND PHYSICAL LIMITATIONS, TO RECEIVE AN EXAM/PROCEDURE OUTSIDE THIS LOCATION. THIS TEST IS MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF THE PATIENT

Digital X-Ray

☐ Skull		☐ Shoulder	R L
☐ Nasal		☐ Clavicle	R L
☐ Chest		☐ Humerus	R L
☐ Ribs	R L	☐ Elbow	R L
☐ Scoliosis		☐ Forearm	R L
☐ Abdomen		☐ Wrist	R L
☐ Cervical		☐ Hand	R L
☐ Cervical Flex Ext		☐ Femur	R L
☐ Thoracic		☐ Knee	R L
☐ Lumbar		☐ Tib/Fib	R L
☐ Lumbar Flex Ext		☐ Ankle	R L
☐ Sacrum+Coccyx		☐ Foot	R L
☐ SI Joints		☐ Calcaneus	R L
☐ TMJ	R L	☐ Toes	R L
☐ Bone Age		☐ Hip	R L
☐ Pelvis			
☐ Finger	R L 1 2 3 4 5		

Other______________________________

☐ # of Views of Exam ______________

Reason for Portable Exam

☐ Patient Bed Ridden

☐ Patient Bed Bound

☐ Patient Wheelchair Bound

☐ Patient Non-Ambulatory

Other______________________________

☐ Patient Signature

____

☐ Patient Unable to Sign

Date Signed:______________________

Ultrasound

☐ Abdomen/Elastography

☐ Gall Bladder O Ejection Fraction

☐ Pelvis/Doppler

☐ Renal/Bladder

☐ Testicular

☐ Bladder

☐ Prostate

☐ Abdomen

☐ Pelvis

☐ Breast R L

☐ Thyroid

Other______________________________

—Vascular—

☐ Carotids

☐ Venous Doppler
- O Upper R L
- O Lower R L

☐ Arterial Doppler
- O Upper R L
- O Lower R L

Other______________________________

Dexa Bone Densitometry

☐ Hip R L

☐ Wrist R L

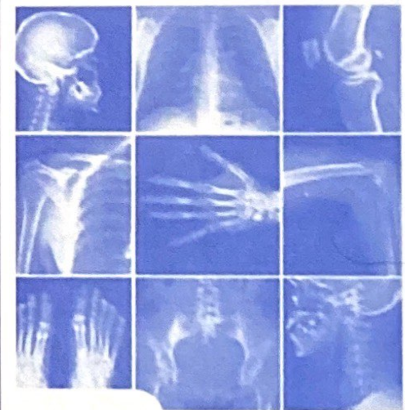
☐ Forearm R L

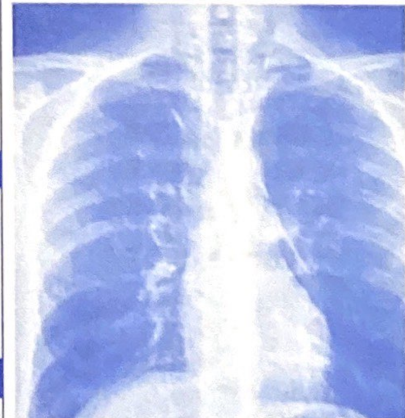
Other______________________

EKG

☐ With Interpretation

☐ Without Interpretation





I certify that the doctor's order and medical necessity for the exam(s) ordered above is documented in the patient's medical chart. I have identified the ordered number of views to be completed with a check mark

☐ Verbal Order Read Back

V.O.______________________________ Date/Time ______________________________

Nurses Signature ______________________________ Date Signed: ______________________