LifeCare Imaging, INC

900 Jorie blvd Suite 20, Oak Brook, IL. 60523
Tel: (800) 919-1761 Fax: (800) 919-1761
Order@lifecareimaging.com

Please Print

Name: Last: First: Date:

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:

Commercial Insurance. HMO / PPO:

Policy:

Group:

Financial Power of Attorney:

Name:

City: State: ZipCode:

Tel: (home) , (cell)

Nurse 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 physical limitations, to receive an X-Ray / IDTF procedure outside is home. 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-RAY PROCEDURES

T. Tube Yes ---- No

CHEST

_____AP ONLY
_____RIGHT RIBS
_____LEFT RIBS

SKULL

_____SKULL SERIES
_____FACIAL BONES
_____ORBIT VIEWS
_____MANDIBLE
_____SINUS SERIES
_____NASAL BONES

SPINE/PELVIS

_____CERVICAL SPINE
_____DORSAL SPINE
_____LUMBAR SPINE
_____SACRUM & COCCYX
_____PELVIS
_____ABD-KUB

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

OFFICIAL USE ONLY

CHART NO:
DATE BILLED:
BILLED BY:

ULTRASOUND

_____ABDOMINAL COMPLETE
_____RENAL (KIDNEY) COMPLETE
_____OB COMPLETE
_____PELVIC NON-OB COMPLETE
_____SOCTRUM
_____THYROID
_____BREAST

CARDIOVASCULAR STUDIES

_____EKG
_____CAROTID DOPPLER
_____ECHOCARDIOGRAM/CARDIAC DOPPLER
_____ARTERIAL UPPER OR LOWER
_____VENOUS UPPER OR LOWER

OTHERS: (PROCEDURE(S) OR VIEW(S))

Please specify:

REGISTERED TECHNICIAN SECTION

TIME PROCEDURE (S) COMPLETED:

SIGNATURE: DATE:

PREGNANCY 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.
DISCLAIMER: 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.