Mobile Medical Imaging LLC
Phone: 301-680-1900
1-800-680-XRAY (9729)
Fax: 301-680-0920

PORTABLE SERVICE REQUISITION

PATIENT NAME: _____

SOCIAL SECURITY # : _____ GENDER: _____ DATE OF BIRTH: _____

FACILITY: _____ ROOM # _____

PHONE: _____ FAX: _____

SERVICE REQUESTED INFORMATION

SERVICE DATE _____ PRIORITY: _____ ORDERED BY: _____

REFERRING PHYSICIAN: _____ NPI: _____

INSURANCE TYPE	PAYER NAME	HIC/SUBSCRIBER #	POLICY
PRIMARY: (ie. Medicare/HMO)			
SECONDARY: (ie. supplement)			

SKILLED: Y / N / NA HOSPICE: Y / N / NA

RESPONSIBLE PARTY	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	PHONE

X-RAY STUDIES

□ Chest □ AP Only □ AP/Lat
□ Abdomen □ KUB □ Multiple Views
□ Abdomen Multiple Views/AP Chest
□ Ribs □ Left □ Right □ Bilateral
□ Ribs/Chest □ Left □ Right □ Bilateral
□ Thoracic Spine □ Cervical Spine □ L/S-Spine
□ Pelvis □ Sacroiliac Joint □ Sacrum/Coccyx
□ Nasal Bones □ Skull □ Facial Bones
□ Mandible □ Clavicle □ Scapula
□ Shoulder □ Left □ Right □ Bilateral
□ Humerus □ Left □ Right □ Bilateral
□ Elbow □ Left □ Right □ Bilateral

□ Forearm □ Left □ Right □ Bilateral
□ Wrist □ Left □ Right □ Bilateral
□ Hand □ Left □ Right □ Bilateral
□ Finger _____ □ Left □ Right
□ Hip □ Left □ Right □ Bilateral
□ Femur □ Left □ Right □ Bilateral
□ Knee □ Left □ Right □ Bilateral
□ Tibia/Fibula □ Left □ Right □ Bilateral
□ Ankle □ Left □ Right □ Bilateral
□ Foot □ Left □ Right □ Bilateral
□ Heel □ Left □ Right □ Bilateral
□ Toe _____ □ Left □ Right

ULTRASOUND STUDIES

□ OB ____1st ____2nd _____3rd Trimester
□ Abdominal
□ Pelvic - Transabdominal
□ Retroperitoneum
□ Thyroid
□ Testicular

□ Carotid
□ Venous □ Left □ Right _____Ext.
□ Arterial □ Left □ Right _____Ext.
□ Single Organ _____ body part
□ Breast □ Left □ Right
□ Ultrasound Ext. _____ body part

CARDIAC STUDIES

□ Ekg □ Pacemaker Check □ Holter □ Echocardiogram

CLINICAL HISTORY OR SYMPTOMS: Rule Out Not Acceptable

□ Cough □ Wheezing □ Open Wound _____ body part
□ Fever □ Gangrene _____ body part □ Abscess _____ body part
□ Congestion □ Pain _____ body part □ Mass or Lump _____ body part
□ Rales □ Swelling _____ body part □ Cardiomegaly
□ Hypertension □ Edema _____ body part □ Atrial Fibrillation
□ Shortness of Breath □ Cancer _____ body part □ Palpitations
□ Positive PPD □ Injury _____ body part □ Syncope
□ Infiltrate □ DVT _____ body part □ Bruise _____ body part
□ Pleural Effusion □ PVD _____ body part □ F/U Fracture _____ body part
□ CHF □ Ulcer _____ body part □ Tachycardia
□ Bradycardia □ Irregular Pulse □ Tachypnea
□ Other (specify) _____

MEDICAL NECESSITY

This test is medically necessary for the diagnosis and treatment of this patient because the patient has or is:

□ Physical
□ Psychological Limitations
□ Non-Ambulatory/Bed-ridden
□ Dementia
□ Advanced Age
□ Hospice Patient

DOCTOR SIGNATURE_____DATE _____

Nurse Transcribing: _____