Exam Date: _____

ULTRA HEALTHCARE MOBILE X-RAY

DIGITAL X-RAY & ULTRASOUND SERVICES

CONFIRMED/SCHEDULED
DATE:_____
TIME:_____
INITIALS:_____

FOR YOUR ORDER TO BE PROCESSED, ALL REQUIRED BOXES MUST BE CHECKED AND FORM COMPLETELY FILLED OUT.

PHONE: (727) 669-5525 • FAX: (727) 669-8589 •ALTERNATE FAX: (727) 797-9300

TO ORDER AN EXAM PLEASE FAX THIS COMPLETED FORM, THE PATIENT'S FACESHEET AND PHYSICIAN/ARNP ORDER WHICH MUST STATE: "PORTABLE XRAY" TO THE FAX NUMBER LISTED ABOVE.

PLEASE CALL (727) 669-5525 TO CONFIRM ORDER WAS RECEIVED.

Patient Name:_____ Facility:_____
Last First

Gender: M☐ F☐ DOB:_____ SSN:_____ Room:_____

PT Phone:_____ Medicare HIC:_____ Medicaid/Insurance:_____

Symptom/Diagnosis for Exam(s)_____

Portable X-Ray Requested Due To Patient's Medical Condition(s) Listed. Check All That Apply:

- ☐ Advanced State of Senility
- ☐ Alzheimers/Dementia
- ☐ Blindness/RequiresAssistance
- ☐ Confined to Bed
- ☐ Contracture Causing Immobility
- ☐ Heart Disease Limiting Physical Activity
- ☐ History of CVA
- ☐ Late Stages of ALS
- ☐ Muscle Weakness
- ☐ Neurodegenerative Disability
- ☐ Pain/Weakness - Postoperatively
- ☐ Psychosis
- ☐ Respiratory Distress
- ☐ Severe Neuropathy
- ☐ Other:_____

Film/CD Delivery:

Check one: ○ Film ○ CD

Needed by:_____

To Where: Dr._____

Address:_____

_____

Ultrasound

- ☐ Abdominal/Abdominal Doppler
- ☐ Limited Abdominal
- ☐ Abdominal Aorta Duplex
- ☐ Renal
- ☐ Pelvic/Prostate
- ☐ Limited Pelvic/Bladder
- ☐ Breast Bilateral/Unilateral RT / LT ☐
- ☐ Extremity/Soft Tissue-non vascular
- ☐ Thyroid
- ☐ Testicular
- ☐ Pre/Post Void
- ☐ Chest B Scan
- ☐ Carotid Duplex Unilateral RT / LT ☐
- ☐ Carotid Duplex Bilateral
- ☐ Bilateral Upper Duplex Extremity Arterial
- ☐ Unilateral Upper Extremity Arterial RT/LT
- ☐ Bilateral Lower Duplex Extremity Arterial
- ☐ Unilateral Lower Extremity Arterial RT/LT
- ☐ ABI's (Ankle/Brachial Index) RT / LT
- ☐ Bilateral Upper/Lower Venous Doppler
- ☐ Unilateral Upper/Lower Venous Doppler RT / LT
- ☐ 2d Echo, Doppler, Color Flow

☐ Other:_____

X-Ray

- ☐ Abdomen/KUB 1 view
- ☐ Ankle RT / LT 3 views ☐
- ☐ Cervical Spine 2 views
- ☐ Chest 1 View
- ☐ Chest 2 Views
- ☐ Clavicle RT / LT 2 views ☐
- ☐ Elbow RT / LT 2views ☐
- ☐ Facial Bones 3 views
- ☐ Femur RT / LT 2 views ☐
- ☐ Finger RT /LT 2 views ☐
- ☐ Foot RT / LT 3 views ☐
- ☐ Forearm RT / LT 2 views ☐
- ☐ Hand RT / LT 3 views ☐
- ☐ Heel RT / LT 2 views ☐
- ☐ Hip RT / LT 2 views ☐
- ☐ Hip Bilateral w/Pelvis 5 Views
- ☐ Humerus RT / LT 2 views ☐
- ☐ Knee RT / LT 2 views ☐
- ☐ Knee RT / LT 3 views ☐
- ☐ Lumbar Spine 2 views
- ☐ Mandible 3 Views
- ☐ Nasal Bones 3 views
- ☐ Orbits 3 views
- ☐ Pelvis 1 view
- ☐ Ribs Bilateral 3 views each
- ☐ Ribs Bilateral w Chest 7 views
- ☐ Ribs RT / LT 3 views ☐
- ☐ Sacrum-Coccyx 2 views
- ☐ Scapula RT / LT 2views ☐
- ☐ Shoulder RT / LT 2 views ☐
- ☐ Sinus 3 views
- ☐ Skull 3 views
- ☐ Thoracic Spine 2 views
- ☐ Tibia/Fibula RT / LT 2 views ☐
- ☐ Toes RT / LT 2 views ☐
- ☐ Wrist RT / LT 3 views ☐
- ☐ Other:_____

Telephone/Verbal order received by the physician/ARNP listed below:

Physician/ARNP Ordering Exam:_____
Last First

I certify this patient is facility/homebound due to the conditions listed above.

Physician/ARNP Signature:_____ Date_____

I certify the ordering Physician/ARNP orders for these tests are on file at the facility.

Nurse's Signature_____RN/LPN Date_____

Technologist Use Only:

Date:_____ Time:_____ Tech Initials:_____

Tech Comments:_____# Pt's_____

WHITE – OFFICE YELLOW – FACILITY