J.T. IMAGING

Mobile X-Ray & EKG
Tel (626)728-1708
P.O Box 1183 Temple City CA 91780
Fax (626) 941-6566

Today's Date_____ To Be Done_____

Facility:_____ Tel:_____ Fax:_____

Address:

Patient's Name Last First MI	SS#	D.O.B	☐ M ☐ F

Medicare # Medical # PPO:

	Chest/Abdomen				**Extremities**				**Head/Spine**
	Chest 2 views				Shoulder	R	L		Skull
	Ribs	R	L		Elbow	R	L		Facial
	Abdomen 2views				Humerus	R	L		Nasal
	KUB				Forearm	R	L		C.Spine
	Pelvis				Wrist	R	L		T.Spine
					Hand	R	L		L.Spine
					Finger	R	L		
					Hip	R	L		Others
	EKG				Femur	R	L		
	Height				Knee	R	L		
	Weight				Tibia/Fibula	R	L		
	B/P				Ankle	R	L		
					Foot	R	L		
					Toes	R	L		

Referring Physician:_____ Charge Nurse_____

Reason For Exam _____

Signature_____

A portable X-Ray examination is necessary due to Patient's Confinement to health facility.
A Physician's Written order has been obtained. Federal health code
Compliance: Section 5 (Sub.N)Article 405-1414

Tech	Date	Time	Total No of views	Remarks	CC/Trip