American X-Ray Services LLC

Phone: (708) 345-6565 AmericanX-RayServices.com Fax: (708) 345-6595

Last Name _____ Date ____ / _____ / _____

First Name _____ Hospice ❒ Y ❒ N

SSN ___ -- __ __ - ____

Date of Birth __ __ / __ __ / 19 __ __ Sex ❒ M ❒ F

Medicare Part B _____

Address _____

Apt _____ City _____ Zip _____

Phone # (___) ___ ___ - ____

(___) ___ ___ - ____

Agency _____

Physician _____

NPI # _____

Nurse _____

Commercial Insurance/PPO/Responsible Party

Name _____

ID # _____ Group # _____

Address _____

Phone # (___) ___ ___ - ____

I acknowledge that this physician's order is documented in the patient's chart at this agency and available for American X-Ray Services. This portable exam is needed as the patient would find it physically or psychologically strenuous due to age or physical limitations.

Signature _____

Portable X-Ray Procedures

CHEST

_____ Chest (PA) (PA/Lat)
_____ Ribs (BL) (R) (L)

SPINE / ABDOMEN

_____ Cervical Spine
_____ Thoracic Spine
_____ Lumbosacral Spine
_____ Sacrum/Coccyx
_____ Abdomen-KUB

HEAD / FACIAL

_____ Skull Series
_____ Facial Bones
_____ Orbits
_____ Mandible
_____ Sinuses/Nasal

UPPER EXTREMITIES

_____ Clavicle (R) (L)
_____ Scapula (R) (L)
_____ Shoulder (R) (L)
_____ Humerus (R) (L)
_____ Elbow (R) (L)
_____ Forearm (R) (L)
_____ Wrist (R) (L)
_____ Hand/Fingers 1 2 3 4 5 (R) (L)

LOWER EXTREMITIES

_____ Hip/Pelvis (R) (L)
_____ Femur (R) (L)
_____ Knee (R) (L)
_____ Tibia/Fibula (R) (L)
_____ Ankle (R) (L)
_____ Calcaneus (R) (L)
_____ Foot/Toes 1 2 3 4 5 (R) (L)

SYMPTOMS/DX

_____
_____
_____
_____
_____

*Symptoms must be indicated *

Other _____

Note / Comments: _____

Fax Report Attn _____ Fax #(___) ___ - ____ Phone #(___) ___ - ____

Procedure Status: Tech _____ Performed ____ / ____ / ____ Time ____ : ____ By _____
Report Status: Phoned / Faxed Date Faxed ____ / ____ / ____ Time ____ : ____ To _____
Billing Status: Int. _____ Date Billed ____ / ____ / ____ Batch # _____ Paid ____ / ____ / ____

Email: ✉ order@amxrs.com