Reset Form Print Form

**Mobile X-Ray & EKG Request Form**
**Dispatch (208) 994-3424 Fax (801) 783-4657**
**Email: DispatchID@pmdxray.com**
**1351 W. Pine Ave., Ste A, Meridian, ID 83642**

## *FOR COMPLETION BY NURSING STAFF PRIOR TO SERVICE*

**DATE**_____ **STATION**_____ **RM/BED**_____ ☐ **STAT**

**NAME** _____ PHONE(_____)_____

**FAX REPORT TO #** (_____)_____

FUTURE DATE _____/_____/_____

FACILITY NAME/AGENCY _____

TYPE OF X-RAY NEEDED_____

**PATIENT INFORMATION:**

NAME_____ ☐M ☐F
(Last) (First) (M)

SSN_____ D.O.B._____/_____/_____

PRIMARY PHYSICIAN_____PHONE_____

ORDERING PHYSICIAN_____ PHONE_____

*Physician's Signature_____
*Required by Medicare

**For Residences & Foster Care Homes Only**

ADDRESS_____

CITY/STATE/ZIP_____ PHONE(_____)_____

**BILLING INFORMATION** ☐ **Bill Insurance** ☐ **Bill Facility**

Medicare #_____-_____-_____ Medicaid #:_____

Other Insurance_____

Address_____

ID#_____ GRP. ##_____

Responsible Party Name/Address/Phone_____

_____

**SPECIAL INSTRUCTIONS:**_____

_____

| **Preliminary Results** |
|---|
| |
| |
| |
| **Call/Faxed to:** **Time/Date: : am/pm / /** |

### EKG
☐ EKG
HEIGHT_____WEIGHT_____
BLOOD PRESSURE_____
CARDIAC MEDS_____

### REASONS FOR EXAM
- ☐ Congestion/Rales
- ☐ Abn. Bowel Sounds
- ☐ Abn. Heart Rate
- ☐ Abnormal Sputum
- ☐ Abn. Weight Gain
- ☐ Ab. Weight Loss
- ☐ Airway Obst/COPD
- ☐ Constipation
- ☐ Cough
- ☐ Cough w/Blood
- ☐ Cardiac Murmur
- ☐ Diarrhea
- ☐ Distention
- ☐ Dyspnea
- ☐ Dysphagia/Verify NG
- ☐ Edema
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Oxygen Saturation
- ☐ Palpitations
- ☐ Positive PPD
- ☐ Resp. Distress
- ☐ SOB
- ☐ Wheezing

SPECIFIC ICD-10 CODE(s):

_____

OTHER:

_____

### PAIN
Specific Location(s)
#1_____

#2_____

#3_____

#4_____

☐ **CD FILM COPY**
Need Date/Time:_____

## *FOR MOBILE PROVIDER USE ONLY*

### LUNGS/THORACIC
- ☐ Chest, 1V
- ☐ Chest, 4+V
- ☐ Chest, 2V
- ☐ Chest, 3V
- ☐ Ribs, Unil, 3+V L R
- ☐ Ribs, Unil, 2V L R
- ☐ Ribs, Bil, 4+V
- ☐ Ribs, Bil, 3V
- ☐ Sternum, 2+V
- ☐ Employee Chest

### ABDOMEN
- ☐ Abdomen, 1V (KUB)
- ☐ Abdomen, 2V
- ☐ Abdomen, 3V

### SPINE
- ☐ Cervical Spine, 2V
- ☐ Cervical Spine, 4+V
- ☐ Lumbosac. Spine, 2V
- ☐ Lumbosac. Spine 3V
- ☐ Thoracic Spine, 2V
- ☐ Thoracolumbar, 2V
- ☐ Spine, 1V
- ☐ Sacroiliac Jnts. 3+V
- ☐ Sacrum & Coccyx, 2+V

### UPPER EXTREMITIES
- ☐ Clavicle, 2V L R
- ☐ Shoulder, 1V L R
- ☐ Shoulder, 2+V L R
- ☐ Scapula, 2V L R
- ☐ Elbow, 2V L R
- ☐ Elbow, 3+V L R
- ☐ Finger(s) 2+V L R
- ☐ Forearm, 2V L R
- ☐ Hand, 2V L R
- ☐ Hand, 3+V L R
- ☐ Humerus, 2+V L R
- ☐ Wrist, 2V L R
- ☐ Wrist, 3+V L R

### EKG
- ☐ EKG With Interpretation
- ☐ EKG, no interpretation

### PELVIS/ LOWER EXTREMITIES
- ☐ Pelvis, 1V
- ☐ Pelvis, 3+V
- ☐ Hips, Bila.: 2R, 2L, 1Pel.
- ☐ Hip, Unilat, 1V L R
- ☐ Hip, Unilat, 2+V L R
- ☐ Femur, 2V L R
- ☐ Knee, 4+V L R
- ☐ Knee, 2V L R
- ☐ Knee, 3V L R
- ☐ Tibia & Fibula, 2V L R
- ☐ Ankle, 2V L R
- ☐ Ankle, 3+V L R
- ☐ Toes, 2+V L R
- ☐ Foot, 2V / 3V L R
- ☐ Calcaneus, 2+V L R

### SKULL / FACIAL/SINUSES
- ☐ Facial Bones, 1-2V
- ☐ Facial Bones, 3+V
- ☐ Sinuses, 3+V
- ☐ Sinuses, 1-2V
- ☐ Skull, 4+V
- ☐ Skull, 1-3V
- ☐ Orbits, 4+V
- ☐ Mandible, 4+V
- ☐ Mandible, 1-3V
- ☐ Nasal Bones, 3+V

**OTHER EXAMS:**_____

_____

### MOBILE X-RAYS:
- ☐ Portable X-Ray Setup
- ☐ Transportation, 1 pt. 1 loc.
- ☐ Transportation, 2 pt., 1 loc.
- ☐ Transportation, 3 pt., 1 loc.
- ☐ Transportation, 4 pt., 1 loc.
- ☐ EKG only transportation
- ☐ After Hours call

**TECH:**_____

**ARR TIME:**_____am pm

**DEP TIME:**_____am pm