PRESCRIPTION FOR MOBILE X-RAY & ULTRASOUNDS

R I S MOBILE DIAGNOSTIC
BRINGING RADIOLOGY SERVICES TO YOU

FAX ORDERS TO: 305.255.8713 PH: 305.255.8777

STAT ☐ www.RISMOBILE.com

Order Date _____ **Fax Results To** _____ Facility Name _____

PATIENT DEMOGRAPHICS AND SERVICE LOCATION (PLEASE SUBMIT FACESHEET WITH THIS REQUEST):

Patient Name (Last, First, M.I.): ☐ Male ☐ Female _____ Date of Birth _____ Social Security Number _____ Patient Phone Number _____

Facility/Patient Home Address: _____ City, State _____ Zip Code _____ Apartment / Patient Room # _____

Insurance Name: ☐ Medicare ☐ PPO/POS ☐ HMO _____ Policy ID Number _____ HMO **AUTH #** (Required) _____

Service(s) to be performed at: ☐ Patient's Home (12) ☐ ALF (13) ☐ Nursing Facility (32)

PLEASE COMPLETE ALL SECTIONS BELOW AS COMPLETELY AND ACCURATELY AS POSSIBLE:

1	**TEST REQUESTED:** ☐ **X-RAY** ☐ **ULTRASOUND**	
	Area of the body to be exposed/tested (nerves, limbs, quadrant, organ, etc):	
	Number of films requested:	Specific View(s) Needed:
	Reason(s) for X-Ray / Ultrasound **(Indications and/or medical necessity/patient's symptoms):**	
	CPT CODE(S):	ICD-9:
2	**TEST REQUESTED:** ☐ **X-RAY** ☐ **ULTRASOUND**	
	Area of the body to be exposed/tested (nerves, limbs, quadrant, organ, etc)	
	Number of films requested:	Specific View(s) Needed:
	Reason(s) for X-Ray / Ultrasound **(Indications and/or medical necessity/patient's symptoms):**	
	CPT CODE(S):	ICD-9:
3	**TEST REQUESTED:** ☐ **X-RAY** ☐ **ULTRASOUND**	
	Area of the body to be exposed/tested (nerves, limbs, quadrant, organ, etc):	
	Number of films requested:	Specific View(s) Needed:
	Reason(s) for X-Ray / Ultrasound **(Indications and/or medical necessity/patient's symptoms):**	
	CPT CODE(S):	ICD-9:
4	**STATEMENT AS TO WHY MOBILE SERVICE(S) ARE REQUIRED:**	
5	FOR POSITIVE TEST RESULTS, HAS PLAN OF CARE (POC) BEEN ESTABLISHED? ☐ YES ☐ NO, Please Explain:	
6	OTHER THAN X-RAY(S), WHAT PRIOR TEST(S), TREATMENT(S) OR THERAPIES HAVE BEEN INITIATED/COMPLETED (for current condition/complaint):	

PREGNANCY DISCLAIMER: To the best of my knowledge, I am not currently pregnant and authorize R I S Mobile Diagnostic, Inc. to perform x-ray procedure(s) as ordered above. I understand that exposure to x-rays can be harmful to an unborn fetus.

Patient's Signature:		Date:	

Name of Ordering Physician (Please Print) _____ Technologist Signature _____

Signature of Ordering Physician _____ Date

Physician NPI _____ Date Test(s) Performed _____