TODAY'S DATE

DATE EXAM NEEDED

RAINA IMAGING

PHONE: 904-992-9749
866-992-9749
FAX: 904-992-8980 OR
904-212-1508

PRIORITY: ☐ STAT ☐ SAME DAY ☐ NORMAL (Within 24hrs)

PATIENT NAME:

DOB: / / AGE:

ROOM # / BED:

ORDERING PHYSICIAN:

PHONE: ( ) -

FACILITY:

WING:

PHONE: ( ) -

FAX: ( ) -

☐ PORTABLE X-RAY (DIGITAL)

	PROCEDURE	L R B	# OF VIEWS
	ABDOMEN (COMPLETE)		3
	ABDOMEN (FLAT & UPRIGHT)		2
	ABDOMEN (KUB)		1
	ANKLE (AP & LAT)	L R B	2
	ANKLE (COMPLETE)	L R B	3
	CHEST		1
	CHEST (AP & LAT)		2
	CLAVICLE (COMPLETE)	L R B	2
	ELBOW (2 VIEWS)	L R B	2
	ELBOW (COMPLETE)	L R B	3
	FACIAL BONES (1-2 VIEWS)		1 - 2
	FACIAL BONES (3 VIEWS)		3
	FEMUR (AP & LAT)	L R B	2
	FINGERS	L R B	2
	FOOT (AP & LAT)	L R B	2
	FOOT (COMPLETE)	L R B	3
	FOREARM (AP & LAT)	L R B	2
	HAND 2 VIEWS / 3 VIEWS	L R B	2 / 3
	HEEL	L R B	2
	HIP (2 VIEWS)	L R B	2
	HIP (COMPLETE)	L R B	5
	HUMERUS	L R B	2
	KNEE 2 VIEWS / 3 VIEWS	L R B	2 / 3
	MANDIBLE (1-3 VIEWS)		1 - 3
	NASAL BONES		3
	ORBITS		2
	PELVIS		1 - 2
	RIBS (UNILAT INCL. AP CHEST)	L R B	3
	RIBS (BILAT INCL. AP CHEST)		4
	SACRUM / COCCYX		2
	SCAPULA (COMPLETE)	L R B	2
	SHOULDER (COMPLETE)	L R B	2 - 3
	SINUSES		1 -3
	SKULL		1 - 3
	SKULL (COMPLETE)		4
	SPINE CERVICAL (AP & LAT)		2
	SPINE CERVICAL (COMPLETE)		4
	SPINE LUMBAR 2V / 3V		2 / 3
	SPINE THORACIC 2V / 3V		2 / 3
	TIBIA / FIBULA	L R B	2
	TOES	L R B	1 - 2
	WRIST (PA & LAT)	L R B	2
	WRIST (COMPLETE)	L R B	3
	OTHER:		

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND / OR INSURANCE BENEFITS BE MADE ON MY BEHALF TO RAINA IMAGING, INC. AND / OR THE INTERPRETING PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE AND MEDICAID SERVICE AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

X

PATIENT'S SIGNATURE

☐ **Nurses Check Here if Patient Is Unable To Sign**

ORDERING PHYSICIAN: **LAST** **FIRST** **PHONE**

I ATTEST THAT I HAVE RECEIVED AN ORDER FOR THE DIAGNOSTIC TEST INDICATED BY THE ORDERING PHYSICIAN, A WRITTEN ORDER FOR WHICH IS DETAILED IN THE PATIENT'S MEDICAL RECORDS KEPT AT THE FACILITY, AND WILL BE SIGNED BY THE PHYSICIAN AT THE NEXT VISIT. PER THE ORDERING PHYSICIAN REFERENCED, THIS PATIENT WOULD FIND IT PHYSICALLY AND/OR PSYCHOLOGICALLY TAXING BECAUSE OF ADVANCED AGE AND/OR PHYSICAL LIMITATION TO RECEIVE A DIAGNOSTIC TEST OUTSIDE THIS LOCATION, THEREFORE MUST BE DONE ON A PORTABLE/MOBILE BASIS. THIS TEST IS MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF THIS PATIENT.

X

LICENSED NURSE'S SIGNATURE REQUIRED **DATE**

X

PHYSICIAN'S SIGNATURE REQUIRED **DATE**

☐ ECG (ELECTROCARDIOGRAM, 12 LEAD)

☐ ECHO (DIGITAL ECHOCARDIOGRAM, COMPLETE)

ULTRASOUND & DOPPLER (DIGITAL)

NON VASCULAR:

- ☐ ABDOMEN COMPLETE (NPO 8 hours)
- ☐ ABDOMEN RUQ (GB/LIVER (NPO 8 hours)
- ☐ BLADDER - PRE/POST VOID (Drink Water)
- ☐ MASS (SOFT TISSUE) Location:
- ☐ PELVIS (NON OB) (drink water)
- ☐ RENAL / BLADDER (Drink Water)
- ☐ TESTICULAR/SCROTUM (with color flow)
- ☐ THYROID
- ☐ **OTHER:**

VASCULAR:

- ☐ AORTA (NPO 8 hours)
- ☐ CAROTID DOPPLER
- ☐ VENOUS DOPPLER / DVT
  UPPER / LOWER EXTREMITY R L B
- ☐ ARTERIAL DOPPLER with ABIs
  UPPER / LOWER EXTREMITY R L B
- ☐ RENAL ARTERY DOPPLER (NPO 8 hours)
- ☐ IVC (inferior vena cava)

OTHER:

SIGNS, SYMPTOMS, OR DIAGNOSIS

☐ Abdo. distention	☐ Hypertension
☐ Abdominal mass	☐ Hypoxia
☐ Abdominal pain	☐ Jaundice
☐ A-Fib	☐ Kidney stone
☐ Aortic stenosis	☐ Mass
☐ Arrhythmia	☐ Nausea
☐ Aspiration	☐ +PPD
☐ Bowel obstruct.	☐ Palpitations
☐ Bruit	☐ PAD / PVD
☐ Cardiomegaly	☐ Pelvic mass
☐ Carotid stenosis	☐ Pelvic pain
☐ Chest Pain	☐ PICC
☐ CHF	☐ Pneumonia
☐ Claudication	☐ PVCs
☐ Congestion	☐ Renal failure
☐ COPD	☐ SOB
☐ Cough	☐ Swelling
☐ DVT	☐ Syncope
☐ Diarrhea	☐ Tachycardia
☐ Dizziness	☐ TIA
☐ Edema	☐ Urinary retention
☐ Fever	☐ Vomiting
☐ Heart murmur	☐ Wheezing
☐ Hematuria	

OTHER:

PAIN WITH OR W/O FALL:

☐ Ankle	☐ Face	☐ Head	☐ Knee	☐ Ribs	☐ Tibia / Fibula
☐ C-Spine	☐ Fingers	☐ Heel	☐ Lumbar Spine	☐ Shoulder	☐ Toes
☐ Elbow	☐ Forearm	☐ Hip	☐ Neck	☐ Thigh	☐ Wrist
☐ Foot	☐ Hand	☐ Humerus	☐ Pelvis	☐ Thoracic spine	

TECHNOLOGIST: DATE: / / NUMBER OF PATIENTS: OF

FACE SHEET MUST BE ATTACHED ☐ A ☐ B ☐ O _____