Requisition Form

110 S Hager Ave., Ste 202 F
Barrington IL 60010
Phone: 773-389-5767
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Patient Data

Name ______________________ Address ______________________ ______________________
Last *First* *Middle*

SSN: ______ - ______ - ______ Sex: **M** **F** DOB ____ / ____ / ______ Tel. # __________
MM DD YYYY

Medicare # ________________ Other Ins. ______________ __________ ______________

Facility Information

Facility ______________ Tel# ______________ Fax# ______________ Date ____ / ____ / ____
MM DD YY

Address ______________________ City __________ State __________ Zip ______________

Authorization

Req. Physician ______________________ NPI# ______________
10 Digits

Ordered By ______________________ NPI# ______________
10 Digits

Signature ____

History

____
____
____

CHEST

_______ Chest Single View
_______ Chest Two Views
_______ L R Ribs

SPINE/PELVIS

_______ Spine-Cervical
_______ Spine-Thoracic
_______ Spine-Lumbar
_______ Sacrum & Coccyx
_______ Pelvis
_______ Abdominal – KUB

SKULL

_______ Skull Series
_______ Facial Bones
_______ Nasal Bones
_______ Sinus Series
_______ Orbit Views
_______ Mandible

EXTREMITIES

_____ L R Clavicle
_____ L R AC Joint
_____ L R SC Joint
_____ Sternum
_____ L R Scapula
_____ L R Shoulder
_____ L R Humerus
_____ L R Elbow
_____ L R Forearm
_____ L R Wrist
_____ L R Hand
_____ L R Finger
_____ L R Hip
_____ L R Femur
_____ L R Knee
_____ L R Tibia/Fibula
_____ L R Ankle
_____ L R Foot
_____ L R Toes
_____ L R Calcaneus

CARDIOVASCULAR STUDY

_____ 2D M-mode Cardiac Doppler
_____ Echocardiogram
_____ EKG
_____ Arterial Doppler Lower / Upper
_____ Venous Doppler Lower / Upper
_____ Carotid Doppler

ULTRASOUND

_____ Abdomen
_____ Abdominal Complete
_____ Abdominal Aortic Aneurysm
_____ Breast
_____ Musculoskeletal
_____ Pelvic (Non-OB) Complete
_____ Renal (Kidney) Complete
_____ Scrotum
_____ Thyroid