



24/7 SERVICE

DISPATCH: 844-990-1335
FAX ORDER TO: 855-283-1817
EMAIL ORDER: info@hciradiology.com

Order Date: _____

STAT, Please Call ROUTINE

CLIENT INFORMATION

Name: _____ Ordering Contact: _____
 Phone No: _____ Fax Report to Doctor at: _____
 Ordering Physician: _____ *Physician Signature: _____
Last, First

PATIENT INFORMATION

Name: _____ Phone No: _____
 Address/Facility: _____ City, State, Zip: _____
 D.O.B.: _____ Gender: _____

INSURANCE

Bill Facility OR Bill Insurance (or attach a Face-Sheet)
 Medicare # _____ Medicaid # _____
 Other Insurance _____ ID# _____ GRP # _____
 Responsible Party Name/Address/Phone _____

Reason for Exam: _____

PROCEDURES ORDERED

CHEST / ABDOMEN	UPPER EXTREMITIES	ULTRASOUND	ELECTROCARDIOGRAM
<input type="checkbox"/> Chest AP & Lat 71020	<input type="checkbox"/> Clavicle, complete <input type="checkbox"/> L <input type="checkbox"/> R 73000	<input type="checkbox"/> US Thyroid/Neck 76536	<input type="checkbox"/> EKG 93000
<input type="checkbox"/> Chest AP 71010	<input type="checkbox"/> Shoulder, 1V <input type="checkbox"/> L <input type="checkbox"/> R 73020	<input type="checkbox"/> US Breast <input type="checkbox"/> L <input type="checkbox"/> R 76641	
<input type="checkbox"/> Rib, 2V <input type="checkbox"/> L <input type="checkbox"/> R 71100	<input type="checkbox"/> Shoulder, 2+V <input type="checkbox"/> L <input type="checkbox"/> R 73030	<input type="checkbox"/> US Chest 76604	ECHOCARDIOGRAM
<input type="checkbox"/> Rib, Bilateral, 3V 71110	<input type="checkbox"/> Humerus 2+V <input type="checkbox"/> L <input type="checkbox"/> R 73060	<input type="checkbox"/> US Abdominal 76700	<input type="checkbox"/> Echocardiogram 93306
<input type="checkbox"/> Abdomen, 1V 74000	<input type="checkbox"/> Elbow, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73070	<input type="checkbox"/> US Retroperitoneal 76770	
	<input type="checkbox"/> Forearm, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73090	<input type="checkbox"/> US Ext Non Vascular 76880	OTHER EXAM
HEAD & NECK	<input type="checkbox"/> Wrist, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73100	<input type="checkbox"/> US OB Pregnant Uterus 76805	
<input type="checkbox"/> Sinuses, paranasal: <3V 70210	<input type="checkbox"/> Hand, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73120	<input type="checkbox"/> US Pelvis (non-OB) 76856	
<input type="checkbox"/> Skull 4 views 70260	<input type="checkbox"/> Finger(s), 2+V <input type="checkbox"/> L <input type="checkbox"/> R 73140	<input type="checkbox"/> US Scrotum 76870	
<input type="checkbox"/> Facial Bones, <3V 70140		<input type="checkbox"/> US Testical 93975	
<input type="checkbox"/> Nasal Bones, 3+V 70160	LOWER EXTREMITIES	<input type="checkbox"/> US Carotid 93880	
	<input type="checkbox"/> Hip, Unil: 1V <input type="checkbox"/> L <input type="checkbox"/> R 73501	<input type="checkbox"/> Ankle/Brachial Index 93922	
SPINE & PELVIS	<input type="checkbox"/> Hip, complete: 2V <input type="checkbox"/> L <input type="checkbox"/> R 73502	<input type="checkbox"/> US Arterial LE <input type="checkbox"/> L <input type="checkbox"/> R 93925	
<input type="checkbox"/> Cervical, 2V or 3V 72040	<input type="checkbox"/> Femur, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73552	<input type="checkbox"/> US Arterial UE <input type="checkbox"/> L <input type="checkbox"/> R 93930	
<input type="checkbox"/> Lumbrosacral, 2V 72100	<input type="checkbox"/> Knee, 1V or 2V <input type="checkbox"/> L <input type="checkbox"/> R 73560	<input type="checkbox"/> US Venous LE <input type="checkbox"/> L <input type="checkbox"/> R 93970	
<input type="checkbox"/> T-Spine, 2V 72070	<input type="checkbox"/> Tibia & Fibula, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73590	<input type="checkbox"/> US Venous UE <input type="checkbox"/> L <input type="checkbox"/> R 93970	
<input type="checkbox"/> Pelvis, AP only 72170	<input type="checkbox"/> Ankle, 2V <input type="checkbox"/> L <input type="checkbox"/> R 73600	<input type="checkbox"/> US Vascular Retroperitoneal 93975	
	<input type="checkbox"/> Foot: 2V <input type="checkbox"/> L <input type="checkbox"/> R 73620	<input type="checkbox"/> Segmental Pressures Low Ext 93923	
	<input type="checkbox"/> Toe(s), 2+V <input type="checkbox"/> L <input type="checkbox"/> R 73660		

PORTABLE ORDER FORM

*Portable exam is necessary because transporting the patient would be detrimental to the patient's wellbeing. The test is medically necessary for the diagnosis and treatment of this patient.