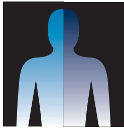

FASTRAD
MOBILE RADIOLOGY

1-888-594-5910

101 N. 3rd Street
Brooklyn, NY 11211

405 Candlewood Commons
Howell, NJ 07731

Tel: 718.594.1001
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EKG-ULTRASOUND-ECHO REQUISITION
HOMEBOUND SERVICE

Accession Number

PT Account #

Date of Service M_______ D_____ / 2009

Facility Name____________________________ Room #____________

PATIENT NAME____
LAST FIRST

DATE OF BIRTH M_______D_______Y_______ male female

SOCIAL SECURITY # __________ - __________ - __________

ADDRESS____

PHONE ____

MEDICARE # ____

MEDICAID #____

INSURANCE CO. ______________________________________

POLICY #____

PREAUTHORIZATION #___________________________________

PATIENT: ❑ SNF ❑ HOMEBOUND ❑ OTHER

Please Check One or More Below:

- ❑ **ABDOMINAL/RENAL**
- ❑ **CAROTID/THYROID**
- ❑ **PELVIC**
- ❑ **BILATERAL VENOUS & ARTERIAL DOPPLER**
  - ❑ **Upper** ❑ **Lower** ❑ **Both**
- ❑ **BILATERAL VENOUS DOPPLER**
  - ❑ **Upper** ❑ **Lower** ❑ **Both**
- ❑ **BILATERAL ARTERIAL DOPPLER**
  - ❑ **Upper** ❑ **Lower** ❑ **Both**

❑ **ECHO**

❑ **EKG** ❑ **X-RAY SPECIFY** ________________

❑ **OTHER** ___________________________________

ORDERING PHYSICIAN

Name: Last _____________________________________

First _____________________________________

Tel. ____

Fax ____

Tech Comments: **Time:**

Clinical Symptoms / Diagnosis Required:

Check all that apply:

- ❑ Peripheral Vascular Complications
- ❑ PVD - Peripheral Vascular Disease
- ❑ Swelling Mass in Neck or Head
- ❑ DVT - Deep Vein Thrombosis
- ❑ Abdominal Distension
- ❑ Infection of Kidney
- ❑ Facial Weakness
- ❑ Abdominal Pain
- ❑ Hypothyroidism
- ❑ Pelvic Swelling
- ❑ Varicose Veins
- ❑ Swelling Limbs
- ❑ Hypertension
- ❑ Pain in Joint
- ❑ Stroke
- ❑ Edema

Other Symptoms Specify:

All Abdominal Studies include Renal. All Arterial Studies include segmental PVR. All Pelvic Studies include Renal/Abdominal.
We will follow any physician modification to this form.
When multiple tests are ordered it may be necessary to perform them on separate occasions.

Person signing below verifies the medical necessity of the test being performed. The signature also verifies the presence of physicians' order for the test being performed. Doctor certifies that this patient, because of age, physical limitations, and for the care of the patient, the exam should not be conducted outside the above location.

Signature____ **Date**__________________________