FASTRAD
MOBILE RADIOLOGY

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Brooklyn, NY 11211

405 Candlewood Commons
Howell, NJ 07731

Tel: 718.594.1001
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EKG-X-RAY REQUISITION HOMEBOUND SERVICE

Accession Number

PT Account #

ORDERING PHYSICIAN

Name: Last _____

First _____

Tel. _____

Fax _____

Tech Name:

Time:

Tech Comments:

Number of patients 1 2 3

DIAGNOSIS/SYMPTOM/REASON REQUIRED

OTHER EXAMS

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

X-RAY EXAMS				# of Views
200	Abdomen			2
210	Chest			
220	Ribs	Rt	Lt	3
UPPER EXTREMITY EXAMS				
230	Clavicle	Rt	Lt	2
240	Elbow	Rt	Lt	3
250	Fingers	Rt	Lt	3
	1 2 3 4 5			
260	Forearm	Rt	Lt	2
270	Hand	Rt	Lt	3
280	Humerus	Rt	Lt	2
290	Scapula	Rt	Lt	2
300	Shoulder	Rt	Lt	2
310	Wrist	Rt	Lt	3
LOWER EXTREMITY EXAMS				
320	Ankle	Rt	Lt	3
330	Femur	Rt	Lt	2
340	Foot	Rt	Lt	3
350	Heel	Rt	Lt	2
360	Hip	Rt	Lt	2
370	Knee	Rt	Lt	3
380	Pelvis	Rt	Lt	3
390	Tibia-Fibula	Rt	Lt	2
400	Toes	Rt	Lt	3
	1 2 3 4 5			
SPINE EXAMS				
440	Cervical			3
450	Lumbosacral			3
460	Sacrum/Coccyx			2
520	Thoracic			3

HEAD OR FACIAL EXAMS		# of Views
470	Facial Bones	3
480	Mandible	3
490	Nasal Bone	3
500	Sinuses	3
510	Skull	3
900	**EKG**	

ULTRASOUND SPECIFY

- Please circle Diag. Code -

SYMPTOMS/DIAGNOSIS/REASON	DIAG. CODE
Chest/Ribs	
Abnormal Chest Sounds	786.7
Chest/Pulmonary Congestion	514
CHF	428.0
Collapsed Lung	518
COPD	496
Cough	786.2
Pain-Chest/Rib	786.50
Pleural Effusion	511.9
Pneumonia	486
Positive PPD	795.5
Shortness of Breath	786.05
Fever/Elev Temp	780.6
Discomfort, Tightness in Chest	786.59
Emphysema	492.8
Respiratory Distress	786.09
Wheezing	786.07
PICC - Line Placement	V58.81

SYMPTOMS/DIAGNOSIS/REASON	DIAG. CODE
Abdomen	
Abnormal Disention	787.3
Abnormal Rigidity	789.4
Abnormal Bowel sounds	787.5
Constipation	564.00
Diarrhea	787.91
Ileus	560.1
Intestinal Obstruction	560.9
Nausea	787.02
Pain-Abdominal (cramps)	789.00
Pain-Stomach	536.8
Vomiting	787.03

SYMPTOMS/DIAGNOSIS/REASON	DIAG. CODE
Skeletal/Bone	
Bruise/Contusion Lower Limb	924.5
Bruise/Contusion Upper Limb	923.9
Edema	782.3
Pain-Ankle	719.47
Pain-Cervical	723.1
Pain-in Limb	729.5
Pain-Head (skull, facial area)	784.0
Pain-Hip	719.45
Pain-Joint	719.40
Pain-Knee	719.46
Pain-Low Back	724.2
Pain-Shoulder	719.41
Pain-Thoracic	724.1
Pain-Wrist	719.48
Sprain/Strain, Unspecified Site	848.9
Swelling Limbs	729.81

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. We will follow any physician modification to this form.

SIGNATURE REQUIRED