# Phone:(916) 905-5363 Fax:(916)877-7693
# FAX ALL ORDERS TO: (916)877-7693
# Include face sheet STAT circle & Call if Exam is STAT!

| DATE TO BE DONE | PATIET: LAST FIRST MI | ROOM# | M | F | DATE OF BIRTH |
|---|---|---|---|---|---|
| | | | | | |

**ORDERING FACILITY:**

**FACILITY ADDRESS:**

**CONTACT:**

**PHONE:** **FAX:**

**PATIENT'S SOCIAL SECURITY NUMBER**

**ORDERING PHYSICIAN**

______________________________________PHONE # ______________________
FIRST LAST

______________________________________PHONE # ______________________
**MANAGED CARE PHYSICIAN**

This patient would find it physically and / or psychologically taxing because of advanced age /or physical limitations to receive an X-RAY outside this location. This test is medically necessary for the diagnosis and treatment of this patient.

**RESPONSIBLE PARTY**

NAME______________________________________________

STREET____________________________________________

CITY______________________STATE________ ZIP______________

PHONE_____________________________________________

**PLEASE INCLUDE COPIES OF THE INSURANCE CARDS**

MEDICARE #_________________________________________

MEDICAID #______________________________STATE __________

CO / OTHER INSURANCE_______________________________

POLICY # ___________________________________________

AGE 55 AND UNDER: I AM/AM NOT PREGNANT. IF YES, SHEILDING WAS USED WHEN POSSIBLE.
PT. SIGNATURE:_______________________________________

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR ANY INSURANCE BENEFITS BE MADE DIRECTLY TO SACRAMENTO IMAGING AND/OR THE INTERPRETING PHYSICIAN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I also acknowledge that all services may not be covered in full by my insurance and I will pay in full any balance due to Sacramento Imaging.

___________________________________________
PATIENT'S SIGNATURE

___________________________________________
MANAGED CARE PHYSICIAN

## ULTRASOUND

76536 Thyroid/Neck
76642 Breast Ultrasound Limited 76700 Abdominal
76770 Retroperitoneal
76880 U/S Ext Non Vascular
76805 OB U/S
76856 Pelvic Ultrasound
76870/93975 Scrotum/Testicle
93880 Carotid Doppler
93922 Ankle/Brachial Index
93923 Segmental Pressures Low Ext
93925 Arterial Doppler Bilat Low Ext
93926 Arterial Doppler Unilateral Low Ext
93930 Arterial Doppler Bilat Upp Ext
93931 Arterial Doppler Unilateral Upp Ext
93970 Venous Doppler Bilat
93971 Venous Doppler Unilateral

❑OBS (Below 16 Weeks)
❑OBS (Above 16 Weeks)
❑OBS (High-risk/problem)

## X-RAY

### Gastro-Urological

74000 Abdomen/KUB (1 view)
74020 Abdomen (2 view)
Q9963 Gastrografin

### Head & Neck

70260 Skull (4 view)
70220 Sinuses (3 view)
70110 Mandible (4 view)
70150 Facial Bones (3 view)
70160 Nasal Bones (3 view)
70200 Orbits (4 view)
70140 Maxilla (2 view)
70360 Soft Tissue Neck (2)

### Chest

71010 Chest (1 view) 71020 Chest (2 view) 71101 Ribs Unilat w/CXR 71111 Ribs Bilat w/CXR 71120 Sternum (2 view)

### RIGHT - LEFT

73010 Scapula (2 view)
73030 Shoulder (2 view)
73000 Clavicle (2 view)
73090 Forearm (2 view)
73080 Elbow (3 view)
73110 Wrist (3 view)
73130 Hand (3 view)
73060 Humerus (2 view)

### Lower Extremity

### RIGHT – LEFT

73510 Hip (2 view))
73520 Hip Bilat (4 view)
73550 Femur (2 view)
73564 Knee (4 view))
73590 Tibia/Fibula (2 view))
73610 Ankle (3 view)
73630 Foot (3 view)
73650 Heel/Calcaneus (2 view)

## CARDIOLOGY

93005 Electrocardiogram EKG
93306 Echocardiogram (2D)

## SLEEP TESTS

95806 Sleep Study W/o Sleep Time
G0399 Home Sleep Test With Type 3 Portable Monitor
95800 Sleep Study

## PULMONARY FUNCTION TEST

94070 Bronchospasm Provocation Test
94010 Spirometry
94060 Spirometry Pre and Post Bronchodilator
94727 Gas Dilution For Lung Volume
94729 CO2/Membrane Diffuse Capacity
94375 Flow Volume Loops
94200 Maximum Breathing Capacity
94618 Pulmonary Stress Testing
94726 Total Lung Capacity - Lung Volume/Plethysmography
94640 Inhalation Treatment
94760 Pulse Oxymetry

**Please Note Reason for Services :**

**NOTES: Symptoms / Brief History/Diagnoses:**

**Billing information:** ❑Insurance:_______________ ❑Self-paid Total charges: $______

R0070 Transportation Q0092 Setup fee
______Chest X-ray ______Abdominal

Paid on account of ❑Visa ❑ M/C ❑ Cash

| DATE TAKEN | TECH | # OF PATIENTS THIS VISIT | # OF VIEWS | CHART # | RADIOLOGIST | R0070-Transport (1 pt) R0075-Transport (>1 pt) 99058-STAT exam (only for Mobile services) Q0092-setup |
|---|---|---|---|---|---|---|
| | | | | | | |