TODAY'S DATE

RAINA IMAGING

# FACESHEET AND SIGNED PHYSICIAN ORDER MUST BE ATTACHED

PHONE: 904-992-9749 866-992-9749 FAX: 904-212-1508

PATIENT NAME:

FACILITY:

WING:

DOB: / / AGE: ROOM # / BED:

PHONE: ( ) -

ORDERING PHYSICIAN: PHONE: ( ) -

FAX: ( ) -

## ☐ PORTABLE X-RAY (DIGITAL)

| PROCEDURE | L R B | # OF VIEWS |
|---|---|---|
| ABDOMEN (COMPLETE W/ CXR) | | 3 |
| ABDOMEN (FLAT & UPRIGHT) | | 2 |
| ABDOMEN (KUB) | | 1 |
| ANKLE (AP & LAT) | L R B | 2 |
| ANKLE (COMPLETE) | L R B | 4 |
| CHEST | | 1 |
| CHEST (AP & LAT) | | 2 |
| CLAVICLE (COMPLETE) | L R B | 2 |
| ELBOW (2 VIEWS) | L R B | 2 |
| ELBOW (COMPLETE) | L R B | 4 |
| FACIAL BONES (3 VIEWS) | | 3 |
| FEMUR (AP & LAT) | L R B | 2 |
| FINGERS | L R B | 3 |
| FOOT (COMPLETE) | L R B | 3 |
| FOREARM (AP & LAT) | L R B | 2 |
| HAND 3 VIEWS | L R B | 3 |
| HEEL | L R B | 2 |
| HIP (2 VIEWS) | L R B | 2 |
| HUMERUS | L R B | 2 |
| KNEE 2 VIEWS / 4 VIEWS | L R B | 2 / 4 |
| MANDIBLE (1-3 VIEWS) | | 1 - 3 |
| NASAL BONES | | 3 |
| ORBITS | | 2 |
| PELVIS | | 1 |
| RIBS (UNILAT INCL. AP CHEST) | L R B | 3 |
| SACRUM / COCCYX | | 2 |
| SCAPULA (COMPLETE) | L R B | 2 |
| SHOULDER (COMPLETE) | L R B | 2 - 3 |
| SINUSES | | 1 -3 |
| SKULL | | 1 - 3 |
| SKULL (COMPLETE) | | 4 |
| SPINE CERVICAL (AP & LAT) | | 2 |
| SPINE LUMBAR 2 VIEWS | | 2 |
| SPINE THORACIC 2 VIEWS | | 2 |
| TIBIA / FIBULA | L R B | 2 |
| TOES | L R B | 3 |
| WRIST ( PA & LAT) | L R B | 2 |
| WRIST (COMPLETE) | L R B | 4 |
| OTHER: | | |

## MANDATORY CMS PORTABLE REQUIREMENT: CMS 486.106

PATIENT'S *SPECIFIC MEDICAL CONDITION AT THE TIME OF THE EXAM,* WHICH SUPPORTS "MEDICAL NECESSITY" FOR THIS EXAM TO BE PERFORMED AS A PORTABLE SERVICE. (MUST LIST SPECIFIC CONDITION)

☐ DEMENTIA ☐ SPECIAL TRANSPORTATION REQUIRED ☐ BEDBOUND
☐ REQUIRES ASSISTIVE DEVICES TO AMBULATE (W/C, WALKER, CANE)
☐ MODERATE/SEVERE PAIN W/MOVEMENT ☐ PSYCHIATRIC DISORDER
☐ ADULT PATIENT WHO REQUIRES ASSISTANCE TO ALL DOCTOR VISITS

☐ OTHER: (Specific) ______________________

I ATTEST THAT I HAVE RECEIVED AN ORDER FOR THE DIAGNOSTIC TEST INDICATED BY THE ORDERING PHYSICIAN, A WRITTEN ORDER FOR WHICH IS DETAILED IN THE PATIENT'S MEDICAL RECORDS KEPT AT THE FACILITY, AND WILL BE SIGNED BY THE PHYSICIAN AT THE NEXT VISIT. PER THE ORDERING PHYSICIAN REFERENCED, THIS PATIENT WOULD FIND IT PHYSICALLY AND/OR PSYCHOLOGICALLY TAXING BECAUSE OF ADVANCED AGE AND/OR PHYSICAL LIMITATION TO RECEIVE A DIAGNOSTIC TEST OUTSIDE THIS LOCATION, THEREFORE MUST BE DONE ON A PORTABLE/MOBILE BASIS. THE TEST RESULTS WERE PROVIDED TO THE ORDERING/TREATING PROVIDER & THOSE RESULTS WILL BE USED IN THE MANAGEMENT/TREATMENT OF THE BENEFICIARY'S SPECIFIC MEDICAL CONDITION. THIS TEST IS MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF THIS PATIENT.

X ______________________
LICENSED NURSE'S SIGNATURE REQUIRED DATE

X ______________________
PHYSICIAN'S SIGNATURE REQUIRED DATE

## ☐ ECG (ELECTROCARDIOGRAM, 12 LEAD)

## ☐ ECHO (DIGITAL ECHOCARDIOGRAM, COMPLETE)

## ULTRASOUND & DOPPLER (DIGITAL)

***NON VASCULAR:***

☐ ABDOMEN COMPLETE (NPO 8 hours)
☐ LMTD ABD (GB/LIVER) (NPO 8 hours)
☐ BLADDER - PRE/POST VOID (Drink Water)
☐ SOFT TISSUE (Palp Mass)/Location: ______________
☐ RENAL
☐ TESTICULAR/SCROTUM (with color flow)
☐ THYROID

***VASCULAR:***

☐ AORTA (NPO 8 hours)
☐ CAROTID DOPPLER
☐ VENOUS DOPPLER / DVT
UPPER / LOWER EXTREMITY R L B
☐ ARTERIAL DOPPLER with ABIs
UPPER / LOWER EXTREMITY R L B
☐ RENAL ARTERY DOPPLER (NPO 8 hours)

**OTHER:**

## *SIGNS, SYMPTOMS, OR DIAGNOSIS*

☐ Abdo. distention
☐ Abdominal mass
☐ Abdominal pain
☐ A-Fib
☐ Aortic stenosis
☐ Arrhythmia
☐ Aspiration
☐ Bowel obstruct.
☐ Bradycardia
☐ Bruit
☐ Cardiomegaly
☐ Carotid stenosis
☐ Chest Pain
☐ CHF
☐ Claudication
☐ Congestion
☐ Constipation
☐ COPD
☐ Cough
☐ DVT
☐ Diarrhea
☐ Dizziness
☐ Edema
☐ Fever
☐ Heart murmur
☐ Hematuria
☐ Hypertension
☐ Hypoxia
☐ Jaundice
☐ Kidney stone
☐ Mass
☐ Nausea
☐ +PPD
☐ Palpitations
☐ PAD / PVD
☐ Pelvic mass
☐ Pelvic pain
☐ PICC
☐ Pneumonia
☐ PVCs
☐ Renal failure
☐ SOB
☐ Swelling
☐ Syncope
☐ Tachycardia
☐ TIA
☐ Urinary retention
☐ Vomiting
☐ Wheezing

**OTHER:**

## *PAIN WITH OR W/O FALL:*

☐ Ankle ☐ Face ☐ Head ☐ Knee ☐ Ribs ☐ Tibia / Fibula
☐ C-Spine ☐ Fingers ☐ Heel ☐ Lumbar Spine ☐ Shoulder ☐ Toes
☐ Elbow ☐ Forearm ☐ Hip ☐ Neck ☐ Thigh ☐ Wrist
☐ Foot ☐ Hand ☐ Humerus ☐ Pelvis ☐ Thoracic spine

TECHNOLOGIST: DATE: / / NUMBER OF PATIENTS: OF

***FACE SHEET MUST BE ATTACHED*** ☐ A ☐ B ☐ O ______________