New York Home X-ray/Ultrasound
3 Arch St, Pawling NY 12564
Ph 845-289-0103 Fax 845-855-1010
Call to access services online

Physician Request for Portable X-ray/Ultrasound

Facility: ______________________________________ Ordering Provider (print please) ________________________________

Ordering Provider Phone_________/_________/_________ Fax_________/_________/_________

Patient Information:

Patient Name: ____ M ☐ F ☐ Date of Birth______/______/______

Street Address____City__________________________________Zip__________

Primary Phone_________/_________/_________ Secondary Phone_________/_________/_________

Does the patient have a chair lift in the home? Y ☐ **N** ☐

Medicare ID____ Medicaid ID_______________________________________

Service to be performed on ______/______/______

Patient Symptoms (please be specific, **Cannot** use "Rule out")____

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Condition preventing patient from traveling to outside facility for exam:

☐ Dementia ☐ Non-Ambulatory/Bedridden ☐ Severe gait abnormality ☐ Weakness/Frailty ☐ Poor Balance, unsafe to walk

☐ Severe pain on movement ☐ Maximum assistance to leave home ☐ Hospice ☐ Other___________________________

Chest and Thorax		Lower Extremities		Ultrasounds	
☐ Chest X-ray 1 view		☐ Hip with Pelvis 2-3 views	LT RT	☐ Upper Extremity Venous	LT RT
☐ Chest X-ray 2 view		☐ Hips BILATERAL 4 views		☐ Lower Extremity Venous	LT RT
☐ Ribs Unilateral 2 view	LT RT	☐ Femur 2 views	LT RT	☐ Upper Extremity Arterial	LT RT
☐ Ribs Unilateral W/ Chest 3+ views	LT RT	☐ Knee 3 Views	LT RT	☐ Lower Extremity Arterial	LT RT
☐ Ribs Bilateral W/ Chest 4 views		☐ Tibia/Fibula 2 views	LT RT	☐ Echocardiogram	
Upper extremities		☐ Ankle 3 views	LT RT	☐ Bilateral Carotid	
☐ Shoulder 2 view	LT RT	☐ Foot 3 views	LT RT	☐ Abdominal Complete	
☐ Clavicle 2 view	LT RT	☐ Heel/Harris 2 views	LT RT	☐ Retroperitoneal	
☐ Humerus 2 view	LT RT	☐ Toes 2 views	LT RT	☐ Pelvic	
☐ Forearm 2 view	LT RT	**Spinal Column**		☐ Thyroid	
☐ Elbow 3 view	LT RT	☐ Lumbosacral 2 or 3 views		**Cardiac Exams**	
☐ Wrist 3 view	LT RT	☐ Cervical 3 views		☐ 12 Lead EKG	
☐ Hand 3 view	LT RT	☐ Thoracic 2 views		☐ 24 hour holter monitor	
☐ Fingers 2 views	LT RT	☐ Pelvis 1 view		☐ 7 Day telemetry monitor	
Abdominal		**Head**		☐ 30 Day telemetry monitor	
☐ ABD 1 view		☐ Skull 4 views			
☐ ABD 2 view supine/upright		☐ Facial bones 3 views			
		☐ Nasal bones 3 views			
		☐ Mandible 4 views			
		☐ Sinuses 3 views			

Statement concerning the condition of the patient to warrant portable x-ray service: The exam(s) that I ordered for this patient were medically indicated and necessary for the treatment and/or diagnosis. The patient would find it physically and/or psychologically taxing to receive x-ray services in a place other than the exam site due to the reason(s) documented on this form. Furthermore, it would be detrimental to the patient's physical and or mental condition to be transported for this procedure. I understand that this information may be used by CMS to support the determination of medical necessity of portable x-ray services and that I have personal knowledge of the patient's condition at the time of service. CFR 410.32 (a) Test must be ordered by the physician who is treating the beneficiary and will use the results in the management of the beneficiaries' specific medical problem.

Ordering Provider Signature___________________________________**Date**______/______/______