

X-RAY IMAGING ORDER FORM

Patient Information

Patient Name		DOB	
Phone	Email		
Address	City	State	Zip

Provider Information

Provider Name		NPI	
Office Name			
Office Address	City	State	Zip
Office Phone	Fax		

XRAY

Body Part	Views	Body Part	Views
Abdomen	<input type="checkbox"/> 1 (74018) <input type="checkbox"/> 2 (74019) <input type="checkbox"/> 3 (74021)	Mastoids	<input type="checkbox"/> 2 (70120) <input type="checkbox"/> 3 (70130)
Ankle <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 2 (73600) <input type="checkbox"/> 3 (73610)	Nasal Bones	<input type="checkbox"/> 3 (70160)
Cervical Spine	<input type="checkbox"/> 3 (72070) <input type="checkbox"/> 4 (72050) <input type="checkbox"/> Compl. (75052)	Neck	<input type="checkbox"/> 1 (70360)
Chest	<input type="checkbox"/> 1 (71045) <input type="checkbox"/> 2 (71046) <input type="checkbox"/> 3 (71047) <input type="checkbox"/> 4 (71048)	Orbit	<input type="checkbox"/> 4+ (70200)
Clavicle Compl.	<input type="checkbox"/> 1 (73000)	Pelvis	<input type="checkbox"/> 1 (72170) <input type="checkbox"/> 2 (72170)
Elbow <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (73070) <input type="checkbox"/> 2 (73080)	Rib <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 2 (71100) <input type="checkbox"/> 3 (71101)
Facial Bones	<input type="checkbox"/> 2 (70140) <input type="checkbox"/> 3 (70150)	Ribs - Bilateral	<input type="checkbox"/> 3 (71110) <input type="checkbox"/> 4+ (71111)
Femur <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (73551) <input type="checkbox"/> 2 (73552)	Sacroiliac Joints	<input type="checkbox"/> 2 (72200) <input type="checkbox"/> 3 (72202)
Finger(s)	<input type="checkbox"/> 1 (73140)	Scapula Compl.	<input type="checkbox"/> 2 (73010)
Foot <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 2 (74018) <input type="checkbox"/> 3 (73630)	Scoliosis Study	<input type="checkbox"/> 1 (72081) <input type="checkbox"/> 2 (72082) <input type="checkbox"/> 3 (72082) <input type="checkbox"/> 4 (72083) <input type="checkbox"/> 6+ (72084)
Forearm <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (71045)	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (73020) <input type="checkbox"/> 2 (73030)
Hand <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 2 (73120) <input type="checkbox"/> 3 (73130)	Sinuses	<input type="checkbox"/> 3 (70210) <input type="checkbox"/> 4+ (70220)
Hip <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (73501) <input type="checkbox"/> 2 (73502) <input type="checkbox"/> 3 (73502) <input type="checkbox"/> 4 (73503)	Skull	<input type="checkbox"/> 3 (70250) <input type="checkbox"/> 4+ (70260)
Hips -Bilateral	<input type="checkbox"/> 2 (73521) <input type="checkbox"/> 3 (73522) <input type="checkbox"/> 4 (73522) <input type="checkbox"/> 5 (73523)	Sternum	<input type="checkbox"/> 2 (71120) <input type="checkbox"/> 3 (71130)
Knee <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 1 (73560) <input type="checkbox"/> 2 (73560) <input type="checkbox"/> 3 (73562) <input type="checkbox"/> 4 (73564)	Thoracic Spine	<input type="checkbox"/> 2 (71110) <input type="checkbox"/> 3 (71111) <input type="checkbox"/> 4 (72074)
Lumbosacral AP/Lat.	<input type="checkbox"/> 2 (73560) <input type="checkbox"/> 3 (72100) <input type="checkbox"/> 4+ (72110)	Tibia & Fibula	<input type="checkbox"/> 2 (73590)
Lumbosacral, Bending	<input type="checkbox"/> 2 (72120) <input type="checkbox"/> 3 (72120)	Toe(s)	<input type="checkbox"/> 2 (73660)
Lumbosacral Compl.	<input type="checkbox"/> 4+ (72114)	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 2 (73100) <input type="checkbox"/> 3 (73110)
Mandible	<input type="checkbox"/> 3 (71110) <input type="checkbox"/> 4+ (71111)	Other :	

Special Instructions:

Diagnosis/Indications:

ICD-10 Codes:

Physician Signature : _____ Date : _____