

## 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 (72040) <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 (74620) <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 (73090)	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 (72070) <input type="checkbox"/> 3 (72072) <input type="checkbox"/> 4 (72074)
Lumbosacral AP/Lat.	<input type="checkbox"/> 2 (72100) <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 (70100) <input type="checkbox"/> 4+ (70110)	Other :	

Special Instructions:

Diagnosis/Indications:	ICD-10 Codes:
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Physician Signature : \_\_\_\_\_ Date : \_\_\_\_\_