



**DISPATCH: 512-342-8300**  
**FAX ORDER TO: 512-342-8508**

Order Date: \_\_\_\_\_

STAT, Please Call     ROUTINE

**CLIENT INFORMATION**

Name: \_\_\_\_\_ Ordering Contact: \_\_\_\_\_  
 Phone No: \_\_\_\_\_ Fax Report to Doctor at: \_\_\_\_\_  
 Ordering Physician: \_\_\_\_\_ \*Physician Signature: \_\_\_\_\_  
Last, First

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_  
 Address/Facility: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 D.O.B.: \_\_\_\_\_ Gender: \_\_\_\_\_

**INSURANCE**

Bill Facility    OR     Bill Insurance (or attach a Face-Sheet)  
 Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_  
 Other Insurance \_\_\_\_\_ ID# \_\_\_\_\_ GRP # \_\_\_\_\_  
 Responsible Party Name/Address/Phone \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

PROCEDURES ORDERED			
CHEST / ABDOMEN	UPPER EXTREMITIES	ULTRASOUND	ELECTROCARDIOGRAM
<input type="checkbox"/> Chest AP & Lat    71020	<input type="checkbox"/> Clavicle, complete <input type="checkbox"/> L <input type="checkbox"/> R    73000	<input type="checkbox"/> US Thyroid/Neck    76536	<input type="checkbox"/> EKG    93000
<input type="checkbox"/> Chest AP    71010	<input type="checkbox"/> Shoulder, 1V <input type="checkbox"/> L <input type="checkbox"/> R    73020	<input type="checkbox"/> US Breast <input type="checkbox"/> L <input type="checkbox"/> R    76641	
<input type="checkbox"/> Rib, 2V <input type="checkbox"/> L <input type="checkbox"/> R    71100	<input type="checkbox"/> Shoulder, 2+V <input type="checkbox"/> L <input type="checkbox"/> R    73030	<input type="checkbox"/> US Chest    76604	ECHOCARDIOGRAM
<input type="checkbox"/> Rib, Bilateral, 3V    71110	<input type="checkbox"/> Humerus 2+V <input type="checkbox"/> L <input type="checkbox"/> R    73060	<input type="checkbox"/> US Abdominal    76700	<input type="checkbox"/> Echocardiogram    93306
<input type="checkbox"/> Abdomen, 1V    74000	<input type="checkbox"/> Elbow, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73070	<input type="checkbox"/> US Retroperitoneal    76770	
	<input type="checkbox"/> Forearm, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73090	<input type="checkbox"/> US Ext Non Vascular    76880	OTHER EXAM
HEAD & NECK	<input type="checkbox"/> Wrist, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73100	<input type="checkbox"/> US OB Pregnant Uterus    76805	
<input type="checkbox"/> Sinuses, paranasal: <3V    70210	<input type="checkbox"/> Hand, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73120	<input type="checkbox"/> US Pelvis (non-OB)    76856	
<input type="checkbox"/> Skull 4 views    70260	<input type="checkbox"/> Finger(s), 2+V <input type="checkbox"/> L <input type="checkbox"/> R    73140	<input type="checkbox"/> US Scrotum    76870	
<input type="checkbox"/> Facial Bones, <3V    70140		<input type="checkbox"/> US Testical    93975	
<input type="checkbox"/> Nasal Bones, 3+V    70160	LOWER EXTREMITIES	<input type="checkbox"/> US Carotid    93880	
	<input type="checkbox"/> Hip, Unil: 1V <input type="checkbox"/> L <input type="checkbox"/> R    73501	<input type="checkbox"/> Ankle/Brachial Index    93922	
SPINE & PELVIS	<input type="checkbox"/> Hip, complete: 2V <input type="checkbox"/> L <input type="checkbox"/> R    73502	<input type="checkbox"/> US Arterial LE <input type="checkbox"/> L <input type="checkbox"/> R    93925	
<input type="checkbox"/> Cervical, 2V or 3V    72040	<input type="checkbox"/> Femur, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73552	<input type="checkbox"/> US Arterial UE <input type="checkbox"/> L <input type="checkbox"/> R    93930	
<input type="checkbox"/> Lumbrosacral, 2V    72100	<input type="checkbox"/> Knee, 1V or 2V <input type="checkbox"/> L <input type="checkbox"/> R    73560	<input type="checkbox"/> US Venous LE <input type="checkbox"/> L <input type="checkbox"/> R    93970	
<input type="checkbox"/> T-Spine, 2V    72070	<input type="checkbox"/> Tibia & Fibula, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73590	<input type="checkbox"/> US Venous UE <input type="checkbox"/> L <input type="checkbox"/> R    93970	
<input type="checkbox"/> Pelvis, AP only    72170	<input type="checkbox"/> Ankle, 2V <input type="checkbox"/> L <input type="checkbox"/> R    73600	<input type="checkbox"/> US Vascular Retroperitoneal    93975	
	<input type="checkbox"/> Foot: 2V <input type="checkbox"/> L <input type="checkbox"/> R    73620	<input type="checkbox"/> Segmental Pressures Low Ext    93923	
	<input type="checkbox"/> Toe(s), 2+V <input type="checkbox"/> L <input type="checkbox"/> R    73660		

**PORTABLE ORDER FORM**

\*Portable exam is necessary because transporting the patient would be detrimental to the patient's wellbeing. The test is medically necessary for the diagnosis and treatment of this patient.

**FOR MORE INFORMATION VISIT US AT [www.hciradiology.com](http://www.hciradiology.com)**