

# FACESHEET AND SIGNED PHYSICIAN ORDER MUST BE ATTACHED



RAINA IMAGING

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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<b>PATIENT NAME:</b>		<b>FACILITY:</b>	
<b>DOB:</b> /      / <b>AGE:</b>		<b>WING:</b>	
<b>ORDERING PHYSICIAN:</b>		<b>PHONE:</b> (      )      -	
ROOM # / BED:		<b>FAX:</b> (      )      -	

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
<b>OTHER:</b>		

## 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)

**SIGNS, SYMPTOMS, OR DIAGNOSIS**

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

**OTHER:** \_\_\_\_\_

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

<input type="checkbox"/> Ankle	<input type="checkbox"/> Face	<input type="checkbox"/> Head	<input type="checkbox"/> Knee	<input type="checkbox"/> Ribs	<input type="checkbox"/> Tibia / Fibula
<input type="checkbox"/> C-Spine	<input type="checkbox"/> Fingers	<input type="checkbox"/> Heel	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Toes
<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Thigh	<input type="checkbox"/> Wrist
<input type="checkbox"/> Foot	<input type="checkbox"/> Hand	<input type="checkbox"/> Humerus	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Thoracic spine	

**TECHNOLOGIST:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **NUMBER OF PATIENTS:** \_\_\_\_\_ **OF** \_\_\_\_\_

**FACE SHEET MUST BE ATTACHED**

A       B       O \_\_\_\_\_