SPEED OF LIGHT
MOBILE XRAY SERVICES
Phone: 214-360-7707
Fax: 214-360-7701
Fax: 866-875-3838

PHYSICIAN/PRACTITIONER MEDICAL ORDER

Medical Record of Portable X-Ray Services - A copy of this record must be retained as part of the patient medical records.

Medicare requires that the medical records (nurse's notes & physician notes) corroborate with this order. Please provide patient's face sheet including insurance information and physician notes when available.

Date of Order:_____ Ordering Physician/Practitioner: _____

Facility/Nursing Home/Home:_____ RM#: _____

Patient Name: _____ DOB: _____

Address:_____City:_____ST:_____Zip: _____

	Type of X-RAY exam(s) (area of body to be exposed)	# Radiographs/Views
1		
2		
3		
4		

Symptoms/reasons for X-ray(s) _____

_____

Please provide a statement below explaining the reason WHY THIS PATIENT NEEDS THIS X-RAY AT THEIR place of residence INSTEAD OF AN OUTSIDE FACILITY.

This patient needs a "PORTABLE" x-ray instead of being transported to an outside facility due to the following:

_____

_____

_____

Physician/Practitioner Signature:_____

Printed Name:_____ NP#_____

_____
Signature of Nurse Receiving Above Order

_____
Printed Name

_____
Date/Time

Ultrasound/Doppler

Type of Exam: _____

_____

Symptoms/Reason for Ultrasound/Doppler: _____

_____

_____