DIAGNOSTIC IMAGING®

X-ray Order Form

Brunswick
2 Admiral Fitch Ave., Suite A
Brunswick, ME 04011

Scheduling Number: 800.734.4132
Center Number: 207.844.5679
Fax: 207.721.3295

Appointment date and time ❍ Obtain authorization ❍ Schedule patient		
Patient name (as shown on insurance card)	Cell phone	Home phone
Patient DOB	Patient height	Patient weight
Insurance	Insurance ID #	
❍ Workers' comp ❍ Auto	Date of injury	Pre-certification # (if needed)

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? ❍ No ❍ Yes **If yes** ❍ Initial ❍ Subsequent or ❍ Sequela

REPORTING METHOD: ❍ **STAT: Fax report** ❍ **STAT: Call report (phone number to call:)**

X-RAY

- ❍ Skull
- ❍ Orbits
- ❍ Facial bones
- ❍ Chest ❍ PA ❍ Lateral
- ❍ Ribs ❍ L ❍ R ❍ BIL
- ❍ Clavical ❍ L ❍ R ❍ BIL
- ❍ Shoulder ❍ L ❍ R ❍ BIL
- ❍ Humerus ❍ L ❍ R ❍ BIL
- ❍ Elbow ❍ L ❍ R ❍ BIL
- ❍ Forearm ❍ L ❍ R ❍ BIL
- ❍ Wrist ❍ L ❍ R ❍ BIL
- ❍ Hand ❍ L ❍ R ❍ BIL
- ❍ Finger digit ❍ L ❍ R ❍ BIL

Spine
- ❍ Lumbar-3 views (includes AP/LAT/SPOT)
- ❍ Lumbar-4 views (includes AP/LAT/SPOT & OBLIQUES)
- ❍ Cervical-3 views (includes AP/LAT/APOM)
- ❍ Routine cervical-4 views (includes AP/APOM/LAT/OBLIQUES)
- ❍ Thoracic-2 views (includes AP/LAT)
- ❍ Hip ❍ L ❍ R ❍ BIL
- ❍ Pelvis
- ❍ Femur ❍ L ❍ R ❍ BIL
- ❍ Knee ❍ L ❍ R ❍ BIL
- ❍ Tibia/Fibia ❍ L ❍ R ❍ BIL
- ❍ Ankle ❍ L ❍ R ❍ BIL
- ❍ Foot ❍ L ❍ R ❍ BIL
- ❍ Scoliosis series (includes AP/LAT and are standing only) ❍ with shoes ❍ without shoes
- ❍ Abdomen flat plate (KUB)

❍ Other _____

Provider name (print)	Phone #	Fax #
Provider signature (required) Do not use rubber stamp.	**NPI # (required)**	Date