



LV MOBILE IMAGING

Quality Mobile X-RAYS in the Comfort of Your Home

Weslaco: (956) 447-8300 • Fax: (956) 447-8301

Harlingen: (956) 423-8300 • Fax: (956) 423-8303

Brownsville: (956) 554-9729 • Fax: (956) 554-9725

Rio Grande City: (956) 487-8700 • Fax: (956) 487-7032

PATIENT REFERRAL

X-Ray Examinations

Chest

- Chest View (s)
- Ribs Bilateral View (s)
- Ribs Unilateral View (s)
- Abdomen View (s)
- EKG/CHEST View (s)

Upper Extremities

- | | | | |
|--------------------------|--------------------------|----------|----------|
| L | R | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Clavicle | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Humerus | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Forearm | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Finger | View (s) |

Lower Extremities

- | | | | |
|--------------------------|--------------------------|----------------|----------|
| L | R | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Femur | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tibia & Fibula | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot | View (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Toe | View (s) |

Head

- Skull View (s)
- Facial Bones View (s)
- Nasal Bones View (s)
- Paranasal Sinuses View (s)

Spine

- Cervical View (s)
- Thoracic View (s)
- Lumbosacral View (s)
- Sacrum & Coccyx View (s)
- Pelvis View (s)

Diagnosis

Ultrasound Examinations

- Abdominal / Complete*
- Carotid Duplex
- Testicular
- Venous Flow Doppler
- Arterial Flow

- Prostate
- Gallbladder**
- Abdominal Aorta**
- Liver / Pancreas**
- Renal / Bladder

- Thyroid
- Pelvis*
- Soft Tissue

- Other: _____

* Drink 32 oz. of Fluids
 ** NPO (Nothing to Eat or Drink Six Hours Before Exam)

Patient Name: _____ Date: _____ Time: _____

Address: _____ City/State: _____ Zip: _____

Phone Number: _____ DOB: _____

Primary Physician: _____ Phone Number: _____

Medicare #: _____ Medicaid #: _____

Insurance #: _____ INS #: _____

Justification of status requiring Patient receiving Mobile X-Ray services:

- Nursing Home
- In Home - Bed Bound
- No Transportation
- Non-Ambulatory

Other: _____

Physician Signature: _____