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.

Date of Order:_____ Ordering Physician/Practitioner: _____

Referring Account:_____ Phone #:_____ Fax #:_____

Patient Name:_____ DOB:_____ POC Phone #:_____

Secondary Phone#: _____ Patient Social Security #:_____

Patient/Facility Address: _____ RM#_____

City: _____ State: _____ Zip: _____ Gender: Male ☐ Female ☐

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

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

Symptoms/reasons for X-ray(s)_____

STAT: ☐ Routine: ☐ Special Instructions:_____

Ultrasound/Doppler: Type of Exam: _____ Symptom/Reason for Exam: _____

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:_____ NPI# _____

Person Submitting Order:_____ Phone #: _____

Medical Record Attestation Acknowledgement I understand that the medical record for the date of service on this order is accurately documented and notated by the ordering provider at the time of treatment. The information in this document is true and complete to the best of my knowledge. Per federal regulations 42 CFR §486.106 and §410.32 I acknowledge that I am in compliance with medical records pertaining to ordering portable x-rays.

Physician/Practitioner Signature: _____