ORDER FORM: OUTPATIENT X-RAY

NORTHWEST IMAGING CENTER
NORTHWEST SPECIALITY HOSPITAL | PROUDLY OWNED AND OPRATED BY PHYSICIANS

NAME (LAST)		DOB	MM/DD/YYYY
NAME (FIRST)		HOME	
MI		CELL	

PRIMARY INSURANCE		POLICY			
SECONDARY INSURANCE		POLICY			
ADDRESS					
CITY		STATE		ZIP	

REFERRING PHYSICIAN(S)	
CC PHYSICIAN(S)	
FAX	
MD SIGNATURE	
REPORT	❑ STAT
DR. PHONE CALL	

X-RAY

- ❑ ABDOMEN
  - ❑ KUB (1V.)
  - ❑ FLAT AND UPRIGHT (2V.)
  - ❑ ACUTE ABD. SERIES (3V.)
- ❑ ANKLE: R / L
- ❑ CHEST: PA & LAT
- ❑ ELBOW: R / L
- ❑ FEMUR: R / L
- ❑ FOOT: R / L
- ❑ FOREARM: R / L
- ❑ HAND: R / L
- ❑ HIP-BILATERAL: R / L
- ❑ KNEE: R / L
- ❑ PELVIS
- ❑ RIBS: R / L
- ❑ SHOULDER: R / L
- ❑ SPINE
  - ❑ CERVICAL
  - ❑ THORACIC
  - ❑ LUMBAR
- ❑ TIBIA & FIBULA: R / L
- ❑ WRIST: R / L
- ❑ OTHER _____

Please Specify ICD-9 or Narrative Diagnosis:

(Do not use Rule Out, Possible, Suspected, or Routine - these are not diagnoses.)

Note: To ensure correct appropriate care and comply with federal rules and regulations, NWSH's policy is to require a written referral from the treating physician. The referral (order) must include a diagnosis (narrative or ICD-9 code), signs or symptoms pertinent to the exam , and the type of exam requested.

QUESTIONS? CALL (208) 209- 2060

315 W. DALTON AVENUE, COEUR D' ALENE, ID 83815 | PHONE: (208) 209-2060 | FAX: (208) 209-2070