New York Home X-ray/Ultrasound
PH 845-289-0103
Fax 845-855-1010
info@nyhomexray.com

Provider information:

Facility: ______________________________________ Ordering Provider (print please) ________________________________

Facility Address____ Ordering Provider NPI_________________________

Ordering Provider Phone_________/_________/_________ Fax_________/_________/_________

Patient Information:

Patient Name: ____ M ☐ F ☐ Date of Birth______/______/______

Street Address____City__________________________________Zip__________

Primary Phone_________/_________/_________ Secondary Phone_________/_________/_________

Medicare ID____ Medicaid ID_______________________________________

Service to be performed on ______/______/______ **Does the patient have a stair chair lift in the home?** Y ☐ N ☐

Chest and Thorax		Lower Extremities		Ultrasounds	
☐ Chest X-ray 1 view		☐ Hip with Pelvis 2-3 views	LT RT	☐ Upper Extremity Venous	LT RT
☐ Chest X-ray 2 view		☐ Hips BILATERAL 4 views		☐ Lower Extremity Venous	LT RT
☐ Ribs Unilateral 2 view	LT RT	☐ Femur 2 views	LT RT	☐ Upper Extremity Arterial	LT RT
☐ Ribs Unilateral W/ Chest 3+ views	LT RT	☐ Knee 3 Views	LT RT	☐ Lower Extremity Arterial	LT RT
☐ Ribs Bilateral W/ Chest 4 views		☐ Tibia/Fibula 2 views	LT RT	☐ Echocardiogram	
Upper extremities		☐ Ankle 3 views	LT RT	☐ Bilateral Carotid	
☐ Shoulder 2 view	LT RT	☐ Foot 3 views	LT RT	☐ Abdominal Complete	
☐ Clavicle 2 view	LT RT	☐ Heel/Harris 2 views	LT RT	☐ Renal/Bladder	
☐ Humerus 2 view	LT RT	☐ Toes 2 views	LT RT	☐ Pelvic	
☐ Forearm 2 view	LT RT	**Spinal Column**		☐ Thyroid	
☐ Elbow 3 view	LT RT	☐ Lumbosacral 2 or 3 views		**Cardiac Exams**	
☐ Wrist 3 view	LT RT	☐ Cervical 3 views		☐ 12 Lead EKG	
☐ Hand 3 view	LT RT	☐ Thoracic 2 views			
☐ Fingers 2 views	LT RT	☐ Pelvis 1 view		Other exam:	
Abdominal					
☐ ABD 1 view					
☐ ABD 2 view supine/upright					

Symptoms/Reason for exam:____

The reason why this patient needs an x-ray at their place of residence instead of an outside facility must be documented below. – This patient needs a ***PORTABLE*** x-ray at the bedside instead of being transported to an outside facility due to the following condition(s):

Please narrate____

____

Physician/Practitioner signature: ____________________________________Date__________________

2024 Version

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MEDICARE REQUIRED SIGNATURE LOG

Medicare requires that we maintain a signature log for each referring physician.

Please sign and fax back to: 845-855-1010

____

*****Sign your name*****

Referring/Ordering Practitioner: ____

*****Please Print*****

NPI: ______________________________

What is a Signature log? A signature log is a typed list of physicians and NPP's identifying their names with a corresponding had written signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record. -Medicare Learning Network May 2018