CENTER FOR 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 Digi ❍ 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 #
(REQUIRED) Provider Signature Provider signature required. Do not use rubber stamp.	**Ordering Provider's NPI #**	Date