CAREPLUS DIAGNOSTIC SERVICES LLC

2868 Skokie Valley RD, STE # 4, Highland Park, IL 60035. Email: support@uscpds.com
Tel: (847) 306-3340, (847) 780-4363 Fax: (847) 306-3475 Website: www.uscpds.com

CarePlus Diagnostic Service

Patient Name _____ / _____ Date: ____/____/_____
Last Name First Name

Patient Address: _____

Tel: _____ Date of Birth: ☐☐ ☐☐ ☐☐☐☐ M: ☐ F: ☐

S S N: ☐☐☐ ☐☐ ☐☐☐☐ Medicare No: ☐☐☐☐☐☐☐☐☐☐☐

Facility: _____ Phone No: _____ Fax No: _____

Insurance/HMO/PPO or Responsible Party

Room No: _____ Bed No: _____ Insurance Company # _____

Physician Name: _____ Policy # _____

NPI No: _____ Group # _____

Physician Signature: _____ Insurance No # _____

Nurse Name: _____ Nurse Signature: _____

I acknowledge that the physician's order and medical necessity for the exam to be ordered below is documented in the patient's chart. A portable X-Ray / IDTF procedure is being ordered since the patient would find it physically and/or psychologically taxing because of the advanced age and /or physical limitations, to receive an X-Ray /IDTF procedure outside their home. The test is deemed necessary for the diagnosis and treatment of this patient.

CLINICAL INFORMATION : (SYSTEM MUST BE INDICATED FOR MEDICARE COVERAGE): _____

REASON(S) FOR PORTABLE X-RAY / ULTRASOUND (Indications and/or medical necessity):

X-RAY PROCEDURES SKELETAL SYSTEM

TUBE YES NO

CHEST
☐ AP ONLY

RIBS
☐ RIGHT RIBS ☐ LEFT RIBS

SKULL
☐ SKULL SERIES
☐ FACIAL BONES
☐ ORBIT VIEWS
☐ MANDIBLE
☐ SINUS SERIES
☐ NASAL BONES

SPINE / PELVIS
☐ CERVICAL SPINE
☐ DORSAL SPINE (T-SPINE)
☐ LUMBAR SPINE
☐ SACRUM & COCCYX
☐ PELVIS
☐ ABD – KUB (X-RAY)

☐ R – L SCAPULA
☐ R – L CLAVICLE
☐ R – L SHOULDER
☐ R – L HUMERUS
☐ R – L ELBOW
☐ R – L FOREARM
☐ R – L WRIST
☐ R – L HAND / FINGER
☐ R – L HIP
☐ R – L FEMUR
☐ R – L KNEE
☐ R – L TIBIA & FIBULA
☐ R – L ANKLE
☐ R – L FOOT / TOES
☐ R – L CALCANEUS

OTHER: (Procedure or views)

Please Specify: _____

_____

ULTRASOUND PROCEDURES

☐ ABDOMINAL COMPLETE (U/S)
☐ RENAL (KIDNEY) COMPLETE
☐ OB COMPLETE
☐ THYROID
☐ LIVER
☐ SOFT TISSUE-GROIN
☐ TRANSABDOMINAL PROSTATE
☐ OTHER _____

CARDIOVASCULAR STUDIES
☐ CAROTID DOPPLER
☐ ECHOCARDIOGRAM (2D ECHO)
☐ ARTERIAL UPPER ARMS ☐ RIGHT ☐ LEFT
☐ ARTERIAL LOWER LEGS ☐ RIGHT ☐ LEFT
☐ VENOUS UPPER ARMS ☐ RIGHT ☐ LEFT
☐ VENOUS LOWER LEGS ☐ RIGHT ☐ LEFT

☐ EKG – 12 LEADS

Registered Technician Section:
Time Procedure(s) Completed: _____
Signature: _____ Date: ___/___/_____

Pregnancy Disclaimer : To the best of my knowledge, I am not currently pregnant and authorize CarePlus Diagnostics Services LLC. to perform X-Ray / IDTF procedure(s). I understand that exposures to x-ray can be harmful to unborn fetus. Patient Sign : _____ Date : _____

To order Portable Diagnostic Services, Nursing Homes must provide us the Prescribing Physicians Signed order by Fax (or) Mail within 4 weeks. As per (IDPH REQ.405.1411)