

Providing portable diagnostic solutions

SMILE DIAGNOSTIC SERVICES

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Please Print			
Name: Last:	First:	Date	
Date of Birth:	Sex: QM QF	Medicare:	
S.S. No:		Medicaid:	
Facility		Commercial Insurance. HMO / PPO:	
Facility:		Carrier:	
Room No: Bed	No:	Policy:	
Tel: Fax:		Group:	
Physician's Name: M.D./D.O.		Financial Power of Attorney: Name:	
Physician's Signature:			ip Code:
NPI:		Tel: (Home)	(Cell)
Nurse Name:		e:	Date:
Reason for Portable Ultrasound Exam: Symptoms, I	ndications and or Medical Neces	sity must be indicated for Medicare Coverage:	•
ULTRASOUND		CARDIOVASCULAR STU	DIES
☐ ABDOMINAL COMPLETE (U/S)		CAROTID DOPPLER	
RENAL (KIDNEY) COMPLETE		ECHOCARDIOGRAM	
OB COMPLETE		ARTERIAL DOPPLER UPPER-ARM	R - L
PELVIC NON-OB COMPLETE		ARTERIAL DOPPLER LOWER-LEG	
SCROTUM		- VENOCO DOTT EEN OTT EN THAN	R-L
☐ THYROID			R-L
□ BREAST	· · · · · · · · · · · · · · · · · · ·	DEVC 12 LEAD	
TRANSABDOMINAL PROSTATE		EKG-12 LEAD	
REGISTERED TECHNICIAN SECTION	ON		
TIME PROCEDURE(S) COMPLETED:			
TECHNICIAN NAME:	DATE:		
TECHNICIAN INITIAL:	- Priisi -		
TECHNICIAN HATTINES			
TRIP:			

^{*}To order Portable Diagnostic Services, requestor must provide us the Prescribing Physician's Signed Order by Fax (or) Mail.