REQUISITION FORM http://www.medlifeds.com

6352 N. Lincoln Ave., Suite #206
Chicago, IL 60659
Tel. 773. 539. 4100 (24 HRS)
Fax. 773. 539. 9400

222 E. Wisconsin Ave., Suite #2B
Lake Forest, IL 60045
Tel. 847. 582. 1212 (24 HRS)
Fax. 847. 582. 1213

PATIENT DATA

Name ______________________ Address ______________________ Tel# ______________
Last First Middle

SSN: _____-_____-_____ Sex: **M F** DOB ___/___/_____ Room# ______ Bed# ____
CIRCLE ONE MM DD YYYY

Medicare 'A' Resident? **Y N** Medicare # ______________ Medicaid # ______________
CIRCLE ONE

HMPo/PPO/Other ______________ Policy# ______________

FACILITY INFORMATION

Please print

Facility ______________ Tel# ______________ Fax# ______________ Date ___/___/___
MM DD YY

Address ______________ City ________ State ________ Zip ______________

AUTHORIZATION

Req. Physician ______________ NPI# ______________
10 Digits

Ordered By ______________ NPI# ______________
10 Digits

Signature ______________

DIAGNOSIS

____

____

____

SERVICES (X-RAY PROCEDURES)

Please check the appropriate line(s) & circle L or R if applicable

CHEST

- _______ Chest Single View
- _______ Chest Two Views
- _______ L R Ribs

SPINE/PELVIS

- _______ Spine-Cervical
- _______ Spine-Thoracic
- _______ Spine-Lumbar
- _______ Sacrum & Coccyx
- _______ Pelvis
- _______ Abdominal – KUB

SKULL

- _______ Skull Series
- _______ Facial Bones
- _______ Nasal Bones
- _______ Sinus Series
- _______ Orbit Views
- _______ Mandible

EXTREMITIES

- _____ L R Clavicle
- _____ L R AC Joint
- _____ L R SC Joint
- _____ Sternum
- _____ L R Scapula
- _____ L R Shoulder
- _____ L R Humerus
- _____ L R Elbow
- _____ L R Forearm
- _____ L R Wrist
- _____ L R Hand
- _____ L R Finger
- _____ L R Hip
- _____ L R Femur
- _____ L R Knee
- _____ L R Tibia/Fibula
- _____ L R Ankle
- _____ L R Foot
- _____ L R Toes
- _____ L R Calcaneus

CARDIOVASCULAR STUDY

- _____ 2D M-mode Cardiac Doppler
- _____ Echocardiogram
- _____ EKG
- _____ Arterial Doppler Lower / Upper
- _____ Venous Doppler Lower / Upper
- _____ Carotid Doppler

ULTRASOUND

- _____ Abdominal Complete
- _____ Breast
- _____ Musculoskeletal
- _____ OB Complete
- _____ Pelvic Non-OB Complete
- _____ Renal (Kidney) Complete
- _____ Scrotum
- _____ Thyroid

In Compliance with IDPH Req. 404. 1414, the facility must provide MedLife Diagnostic Services with the prescribing physician's signed order within 30 days.