



REQUISITION FORM <http://www.medlifeds.com>



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Tel. 972.325.2202
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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

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