R I S MOBILE DIAGNOSTIC
Bringing Radiology To You

PLEASE INCLUDE CASE SHEET WITH THIS REQUEST
OFFICE NUMBER: 305.255.8777 FAX: 305.255.8713
Rismobile2@gmail.com

STAT ☐

DATE:_____/_____/_____

Fax Results_____ Facility Name _____

PATIENT DEMOGRAPHICS AND SERVICE LOCATION (PLEASE SUBMIT FACE SHEET WITH THIS REQUEST

PATIENT NAME ☐ MALE ☐ FEMALE	DOB	PHONE NUMBER:

FACILITY NAME/PT ADDRESS | CITY, STATE ZIP CODE | APARTMENT NUMBER/PT ROOM

☐ PATIENT HOME (12) ☐ ALF (13) ☐ NH (32)

NAME OF INSURANCE/POLICY ID# ☐ MEDICARE ☐ PPO/POS ☐ HMO

PLEASE COMPLETE ALL SECTINS BELOW COMPLETLY AND ACCURATELY AS POSSIBLE
TEST REQUESTED: ☐ X=RAY ☐ ULTRASOUND

1 Area of the body to be exposed/tested (e.g., body part, limb, quadrant, organ, etc.):

_____

Number of views: _____Diagnosis (DX): _____

2 Area of the body to be exposed/tested (e.g., body part, limb, quadrant, organ, etc.):

_____

Number of views: _____Diagnosis (DX): _____

3 Area of the body to be exposed/tested (e.g., body part, limb, quadrant, organ, etc.):

_____

Number of views: _____Diagnosis (DX): _____

4 Statement regarding the necessity of mobile service(s):

5 Have we established a plan of care (POC) for positive test results? ☐ YES ☐ NO

PREGNANCY DISCLAIMER: To the best of my knowledge, I am not currently pregnant and hereby authorize RIS Mobile Diagnostics, Inc. to perform the x-ray procedures as outlined above. I acknowledge that exposure to x-rays or ultrasounds may pose risks to an unborn fetus. ☐ YES ☐ NO

Ordering Physician Name:_____ Signature: _____

Tech Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY: ☐ R0070: _____ ☐ R0075:_____ ☐ Q0092: _____