



ClearView
DIAGNOSTICS

TO ORDER:

PHONE: 985-354-6001 | FAX: 985-300-8063

6310 LA 182 E., Morgan City, LA 70380

info@clearview-diagnostics.com | www.clearview-diagnostics.com

PORTABLE DIAGNOSTIC STUDY REQUISITION

DATE ____ / ____ / ____

NAME _____ D.O.B. ____ / ____ / ____ SS# _____ ☐ M ☐ F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FACILITY (if applicable) _____ ROOM# _____ PHONE # (____) - ____ - ____

PRIMARY INSURANCE _____ INSURANCE ID _____

SECONDARY INSURANCE _____ INSURANCE ID _____

PROCEDURE REQUESTED (please circle)

PRIORITY (please circle) **STAT ROUTINE**

XRAY

74018	Abdomen, 1 View (KUB)	
71045	Chest 1 View	
71100	Ribs Unilateral 2 Views	L R
71101	Ribs w/Chest Unilateral 3 Views	L R
71110	Ribs Bilateral 3 Views	
71111	Ribs w/ Chest Bilateral 4 Views	
73610	Ankle 3 Views	L R
73000	Clavicle 2 Views	L R
73070	Elbow 2 Views	L R
70150	Facial 3 Views	
73552	Femur 2 Views	L R
73140	Finger(s) 3 Views	L R
73630	Foot 3 Views	L R
73090	Forearm 2 Views	L R
73130	Hand 3 Views	L R
73650	Heel 2 Views	L R
73502	Hip Unilateral 2 Views	L R
73521	Hip Bilateral 2 Views	
72170	Pelvis 1 View	
73560	Knee 2 Views	L R
72040	Spine Cervical 2 Views	
72100	Spine Lumbar 2 Views	
93000	EKG w/ Interpretation	

ULTRASOUND

76700	Abdomen Complete
76705	Abdomen Limited
76770	Retroperitoneal/Renal
93971	Venous Duplex, Unilat
93970	Venous Duplex, Bilat
93880	Carotid Duplex, Unilat
93882	Carotid Duplex, Limited
76536	Thyroid/Neck
76856	Pelvic Complete
93306	Complete Echo w/ Dopler
93307	Complete Echo w/o Dopler
93308	Limited/Follow Up Echo
93320	Dopler Echo Comp Add-on
93321	Dopler Echo Limited Add-on
93325	Color Flow Mapping Add-on

Other Exam: Specify: _____

Diagnosis, Indications/Symptoms:

Why patient is unable to leave facility safely and portable x-ray is medically necessary: _____

Physician Attestation: My signature below certifies that all the above information is accurate and true to the best of my knowledge and that the medical necessity of the portable radiology exam (s) requested is supported by appropriate documentation.

Ordering Physician (Print) _____ **Signature** _____

NOTE: Partner Physicians please use Portal for order entry!