ROADRUNNER RADIOLOGY REFERRAL FORM

866-972-9786 FAX: 254-393-1671
orders@roadrunnerradiology.com

Date of Service _____ /_____ /_____

Ordering Facility/Company _____ Room#_____

PATIENT NAME _____

PATIENT IS: SNF ☐ HOMEBOUND ☐ OTHER ☐

If patient is homebound please put home address

ADDRESS_____

DATE OF BIRTH _____ /_____ /_____ Male ☐ Female ☐ PHONE #_____

SOCIAL SECURITY # _____ - _____ - _____

MEDICARE # _____

MEDICAID # _____

INSURANCE CO./SECONDARY #_____ AUTH. # _____

**PLEASE FAX COPY OF PATIENTS INSURANCE CARD WITH ORDER*

ORDERING PHYSICIAN: MD/DO

LAST NAME: _____

FIRST NAME: _____

NPI #: _____

PORTABLE: XRAY ☐ EKG ☐ ULTRASOUND ☐ FAX REPORT TO: _____

SERVICES AVAILABLE 24/7

OFFICE HOURS
Mon-Fri 7am-7pm

***A doctor's order (written) must be obtained prior to submitting the requisition.*

CHECK ONE - ROUTINE/STAT

X-RAY PROCEDURES

EXAM		# of Views
Abdomen		
Chest		
Ribs	Rt / Lt	
UPPER EXTREMITY EXAMS		
Clavical	Rt / Lt	
Elbow	Rt / Lt	
Fingers	Rt / Lt (1 2 3 4 5)	
Forearm	Rt / Lt	
Hand	Rt / Lt	
Humerus	Rt / Lt	
Scapula	Rt / Lt	
Shoulder	Rt / Lt	
Wrist	Rt / Lt	
LOWER EXTREMITY EXAMS		
Ankle	Rt / Lt	
Femur	Rt / Lt	
Foot	Rt / Lt	
Heel	Rt / Lt	
Hip	Rt / Lt	
Knee	Rt / Lt	
Pelvis	1V 2V	
Tibia-Fibia	Rt / Lt	
Toes	Rt / Lt (1 2 3 4 5)	
Other	Rt / Lt	
SPINE EXAMS		
Cervical		
Lumbosacral		
Sacrum/Coccyx		
Thoracic		
HEAD/FACIAL EXAMS		
Facial Bones		
Mandible		
Nasal Bone		
Sinuses		
Skull		

ULTRASOUND PROCEDURES

CPT	EXAM	
76700, 76770	Complete Abdominal	☐
93970	Bilateral Upper/Lower Extremity Venous Doppler	☐
93971	Lt or Rt Upper/Lower Extremity Venous Doppler	☐
93930	Bilateral Upper Extremity Arterial Doppler	☐
93925	Bilateral Lower Extremity Arterial Doppler	☐
93926	Lt or Rt Lower Extremity Arterial Doppler	☐
93931	Lt or Rt Upper Extremity Arterial Doppler	☐
93880	Bilateral Carotid	☐
76775, 76770	Renal	☐
76700	Gallbladder	☐
93922	Ankle/Brachial Indices Bilateral	☐
76536	Thyroid/Soft Tissue Neck	☐
76856	Pelvic	☐
76882	Soft Tissue Non-Vascular	☐
76770, 93978	Abdominal Aortic Ultrasound	☐
99306	Echocardiogram	☐

Other _____

CLINICAL SYMPTOMS/DIAGNOSIS FOR EXAM

***ATTENTION IMPORTANT**
Medicare regulations require the physician to provide the diagnosis code for each test ordered. It is the Nurse's responsibility to document Diagnosis code on the requisition.

CLINICAL SYMPTOMS

CHEST/RIBS
- ☐ Abnormal Chest Sounds
- ☐ Chest/Pulmonary Congestion
- ☐ CHF
- ☐ Collapsed Lung
- ☐ COPD
- ☐ Cough
- ☐ Pain-Chest/Rib
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Positive PPD
- ☐ Shortness of Breath
- ☐ Fever/Elev Temp
- ☐ Emphysema
- ☐ Respiratory Distress
- ☐ Wheezing
- ☐ PICC-Line Placement
- ☐ Discomfort/Tightness in Chest

ABDOMEN
- ☐ Abdominal Distention
- ☐ Abnormal Rigidity
- ☐ Abnormal Bowel Sounds
- ☐ Constipation
- ☐ Diarrhea
- ☐ Intestinal Obstruction
- ☐ Nausea Alone
- ☐ Nausea & Vomiting
- ☐ Pain-Abdominal
- ☐ Tube Placement
- ☐ Vomiting Alone

SKELETAL/BONE
- ☐ Contusing Lower Limb
- ☐ Contusion Upper Limb
- ☐ Edema
- ☐ Fall
- ☐ Pain-Ankle
- ☐ Pain-Cervical
- ☐ Pain-In Limb
- ☐ Pain-Hip
- ☐ Pain-Joint
- ☐ Pain-Knee
- ☐ Pain-Low Back
- ☐ Pain-Shoulder
- ☐ Pain-Thoracic
- ☐ Sprain/Strain
- ☐ Swelling Limbs

PERSON SIGNING BELOW VERIFIES THE MEDICAL NECESSITY OF THE TEST BEING PERFORMED. THE SIGNATURE ALSO VERIFIES PRESENCE OF PHYSICIAN'S ORDER (WRITTEN) FOR THE TEST BEING PERFORMED.

SIGNATURE REQUIRED: