



# ROADRUNNER RADIOLOGY REFERRAL FORM

PHONE: 866-972-9786

FAX: 254-393-1671

orders@roadrunnerradiology.com

Date of Service \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Ordering Facility/Company \_\_\_\_\_ Room# \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

**\*\*If patient is homebound please put home address**

ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male ☐ Female ☐ PHONE # \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MEDICARE # \_\_\_\_\_

MEDICAID # \_\_\_\_\_

INSURANCE CO./SECONDARY # \_\_\_\_\_

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

## \*ATTENTION IMPORTANT

Medicare requires the DR. to provide the diagnosis code for exams ordered.

**ROUTINE STAT**

## SERVICES AVAILABLE 24/7

### ORDERING PHYSICIAN:

**If NP, PA or RN ordering we need the actual doctor they practice under.**

NAME: \_\_\_\_\_

NPI #: \_\_\_\_\_

FAX REPORT TO: \_\_\_\_\_

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.

ACTUAL (fax) or DIGITAL (email) SIGNATURE REQUIRED:

**Services need to be performed inside facility due to:** \_\_\_\_\_

## ☐ EKG

### X-RAY PROCEDURES

- ☐ Abdomen
- ☐ Chest
- ☐ Ribs Rt / Lt
- ☐ 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
- ☐ 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
- ☐ Cervical
- ☐ Lumbosacral
- ☐ Sacrum/Coccyx

### DIAGNOSIS

- ☐ Thoracic
- ☐ Facial Bones
- ☐ Mandible
- ☐ Nasal Bone
- ☐ Sinuses
- ☐ Skull

### DIAGNOSIS

### ULTRASOUND PROCEDURES

- ☐ Complete Abdominal
- ☐ BUE/BLE Venous Dop.
- ☐ Lt Upper/Lower Ext. Venous Dop.
- ☐ Rt Upper/Lower Ext. Venous Dop.
- ☐ Bilat. Upper Ext. Arterial Dop.
- ☐ Bilat. Lower Ext. Arterial Dop.
- ☐ Lt or Rt Lower Ext. Arterial Dop.
- ☐ Lt or Rt Upper Ext. Arterial Dop.
- ☐ Bilateral Carotid
- ☐ Renal
- ☐ Gallbladder
- ☐ Ankle/Brachial Indices Bilateral
- ☐ Thyroid/Soft Tissue Neck
- ☐ Pelvic
- ☐ Soft Tissue Non-Vascular
- ☐ Abdominal Aortic Ultrasound
- ☐ Echocardiogram

Other \_\_\_\_\_