

CLEARVIEW DIAGNOSTIC

PHYSICIAN

REFERRAL

APPOINTMENT

Date: _____
Time: _____ AM PM

8076 S. Orange Blossom Trail • Orlando Fl 32809
Phone: 407-704-3333 • Fax: 407-601-1963

TAX ID:
NPI:

PATIENT INFORMATION

Patient's Name: _____ DOB: _____ S.S. No: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: _____ Date of Accident: _____ Attorney: _____
Primary Insurance: _____ Claim #: _____ DOT: _____ HOS: _____

PHYSICIAN INFORMATION

Referring Physician: _____ NPI: _____ Tax ID: _____
Referring Clinic: _____ Telephone: _____ Fax: _____
Diagnosis: _____

MRI	MRI	XRAY
Head and Neck	<input type="checkbox"/> Humerus RT LT 73218	<input type="checkbox"/> Finger RT LT 73140
<input type="checkbox"/> Brain w/o 70551	<input type="checkbox"/> Knee RT LT 73721	<input type="checkbox"/> Foot- 3 Views RT LT 73630
<input type="checkbox"/> Brain w & w/o 70553	<input type="checkbox"/> Shoulder RT LT 73221	<input type="checkbox"/> Forearm RT LT 73090
<input type="checkbox"/> IAC w & w/o 70553	<input type="checkbox"/> Tibia/Fibula RT LT 73718	<input type="checkbox"/> Hand- 3 Views RT LT 73130
<input type="checkbox"/> Neck-Soft Tissue w/o 70540	<input type="checkbox"/> Toe RT LT 73721	<input type="checkbox"/> Hip- Bilateral 73520
<input type="checkbox"/> Neck-Soft Tissue w & w/o 70543	<input type="checkbox"/> Wrist RT LT 73221	<input type="checkbox"/> Hip- Unilateral RT LT 73500
<input type="checkbox"/> Orbit w & w/o 70543	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Humerus 73060
<input type="checkbox"/> Pituitary w & w/o 70553	Spine	<input type="checkbox"/> Knee- 3 Views RT LT 73560
<input type="checkbox"/> TMJ RT LT 70336	<input type="checkbox"/> Cervical w/o 72141	<input type="checkbox"/> Knee Bilateral 73562
Body	<input type="checkbox"/> Cervical w & w/o 72156	<input type="checkbox"/> Lumbar Spine 72110
<input type="checkbox"/> Abdomen w/o 74181	<input type="checkbox"/> Lumbar w/o 72148	<input type="checkbox"/> Mandible 70110
<input type="checkbox"/> Abdomen w & w/o 74183	<input type="checkbox"/> Lumbar w & w/o 72158	<input type="checkbox"/> Mastoid 70120
<input type="checkbox"/> Brachial Plexus w/o 71550	<input type="checkbox"/> Thoracic w/o 72146	<input type="checkbox"/> Nasal Bones 70160
<input type="checkbox"/> Brachial Plexus w & w/o 71552	<input type="checkbox"/> Thoracic w & w/o 72157	<input type="checkbox"/> Neck (Soft Tissue) 70360
<input type="checkbox"/> Breast-Uni RT LT 77058	<input type="checkbox"/> 3D Reconstruction 76377	<input type="checkbox"/> Orbits 70200
<input type="checkbox"/> Breast-Bil 77059	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Pelvis- 1 View 72170
<input type="checkbox"/> Pelvis-Soft Tissue w/o 72195	XRAY	<input type="checkbox"/> Ribs- Bilateral 71110
<input type="checkbox"/> Pelvis-Soft Tissue w & w/o 72197	<input type="checkbox"/> Abdominal (KUB) 74000	<input type="checkbox"/> Ribs- Uni RT LT 71110
Musculoskeletal	<input type="checkbox"/> Abdominal 2 Views (Upright & Supine) 74010	<input type="checkbox"/> Sacrum/ Coccyx 72220
<input type="checkbox"/> Ankle RT LT 73721	<input type="checkbox"/> Ankle- 3 Views RT LT 73610	<input type="checkbox"/> Scapula 73010
<input type="checkbox"/> Elbow RT LT 73221	<input type="checkbox"/> Bone Age 77072	<input type="checkbox"/> Scoliosis Series 72090
<input type="checkbox"/> Femur RT LT 73718	<input type="checkbox"/> Heel RT LT 73650	<input type="checkbox"/> Skull (Complete) 70260
<input type="checkbox"/> Finger RT LT 73221	<input type="checkbox"/> Chest 2 Views 71020	<input type="checkbox"/> Shoulder RT LT 73030
<input type="checkbox"/> Forearm RT LT 73218	<input type="checkbox"/> Clavicle RT LT 73000	<input type="checkbox"/> Sacroiliac Joints 3 Views Min. 72200
<input type="checkbox"/> Forefoot RT LT 73718	<input type="checkbox"/> Cervical 72050	<input type="checkbox"/> Sinuses (Complete) 70220
<input type="checkbox"/> Hand RT LT 73218	<input type="checkbox"/> Elbow RT LT 73080	<input type="checkbox"/> Sternum 71120
<input type="checkbox"/> Heel RT LT 73718	<input type="checkbox"/> Orbit 70030	<input type="checkbox"/> Thoracic Spine 72070
<input type="checkbox"/> Hip RT LT 73721	<input type="checkbox"/> Facial Bones 70150	<input type="checkbox"/> Cervical Spine 72050
	<input type="checkbox"/> Femur RT LT 73550	<input type="checkbox"/> Tibia/ Fibula RT LT 73590
		<input type="checkbox"/> TMJ-Bilateral 70330
		<input type="checkbox"/> Toe RT LT 73660
		<input type="checkbox"/> Wrist RT LT 73110
		<input type="checkbox"/> Other: _____

Please refer to patient preparation instruction listed on the back of this form.

Specify exam if not listed above: _____

Physician Signatures: _____

Date: _____