ROADRUNNER X-RAY INC.

PO BOX 2802
SHERMAN, TEXAS 75091

PHONE 903-893-7773 FAX 903-893-7761
CELL 580-380-5444 877-893-7761

DATE OF EXAM: _____

YOUR FACILITY NAME: _____

PHONE: _____ **FAX:** _____

PATIENT NAME: _____
LAST FIRST

M ___ F ___ LAST FOUR SOCIAL SECURITY NUMBER: _____ **DOB:** _____

ADDRESS: _____ **APT/ROOM#**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PATIENT HOME PHONE: _____ **CELL PHONE:** _____

MEDICARE: _____ **OTHER INSURANCE:**

MEDICAID: _____ **COMPANY:** _____

HOSPICE RELATED: Y _____ N _____ **POLICY:** _____

- ☐ **Abdomen (2V)**
- ☐ **Ankle(3V) Rt ___ Lt ___**
- ☐ **C-Spine (2V)**
- ☐ **Calcaneus (2V) Rt ___ Lt ___**
- ☐ **Chest (1 V)**
- ☐ **Chest (2 V)**
- ☐ **Clavicle (2V) Rt ___ Lt ___**
- ☐ **Elbow(2V) Rt ___ Lt ___**
- ☐ **EKG**
- ☐ **Facial Series (3V)**
- ☐ **Femur (2V) Rt ___ Lt ___**
- ☐ **Foot (3V) Rt ___ Lt ___**
- ☐ **Forearm (2V) Rt ___ Lt ___**
- ☐ **Hand (3V) Rt ___ Lt ___**
- ☐ **Hip (2V) Rt ___ Lt ___**
- ☐ **Humerus (2V) Rt ___ Lt ___**
- ☐ **Knee (3V) Rt ___ Lt ___**
- ☐ **KUB (1 V)**
- ☐ **L-Spine (2V)**
- ☐ **Pelvis (1V)**
- ☐ **Ribs (2V) Rt ___ Lt ___**
- ☐ **Sacrum/Coccyx (2V)**
- ☐ **Shoulder (2V) Rt ___ Lt ___**
- ☐ **Sinus Series**
- ☐ **Skull (2V)**
- ☐ **T-Spine (2V)**
- ☐ **Tib/Fib (2V) Rt ___ Lt ___**
- ☐ **Toes (2V) Rt ___ Lt ___**
- ☐ **Wrist (3V) Rt ___ Lt ___**
- ☐ **Other**_____

DIAGNOSIS DESCRIPTION: _____

ICD 10 CODES: _____

DOCTOR: _____ **NPI:** _____
(NP/PA)

DOCTORS SIGNATURE_____

Due to the patient's physical condition this portable radiological exam is necessary for his or her diagnosis and treatment.