ACE DIGITAL IMAGING LLC

Requisition Order Form

In order to provide the best possible services to you and your patients, we request the following information. Please complete all fields below to expediter you request.

Call report to__________________________________
Fax report to__________________________________

Patient Info

Name:_____________________________________SS#__________DATE: ____ /_____/_____ ☐ Male ☐Female
Facility:____Date of Birth: ____ /_____/_____
Health card #___________________________ Referring MD_______________________
Please include a copy of health card information.

Clinical diagnosis:____
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☐**ULTRASOUNDS EXAMS**
- ☐Abdomen
- ☐RUQ
- ☐Spleen
- ☐Female Pelvic (pt needs a full bladder) Transvaginal avalible
- ☐1st trimester pregnacy
- ☐2nd trimester pregnacy
- ☐3rd trimester pregnacy
- ☐Renal
- ☐Breast
- ☐Grafts/fistula (for patency only)
- ☐Soft tissue
- ☐Scotum/testicle
- ☐Thyroid
- ☐Abscess
- ☐Bladder scans
- ☐Ingunal area
- ☐Appendix
- ☐Axilla

☐**PEDIATRIC EXAMS**

Age of Infant______
- ☐Pyloric stenosis
- ☐Head (8 week or less age)
- ☐Scrotum/ testicle

☐**CARDIOLOGY EXAMS**
- ☐Echocardiogram
- ☐Blood pressure check
- ☐EKG'S
- ☐Carotid duplex
- ☐Upper extremity vein (unilateral, bilateral)
- ☐Upper extremity arterial (unilateral, bilateral)
- ☐Lower extremity vein (unilateral, bilateral)
- ☐Lower extremity arterial (unilateral, bilateral) ABI manual
- ☐Aorta (for AAA)

XRAY EXAMS

ABDOMEN
- ☐Single/ KUB
- ☐Acute (include PA and Chest)

HEAD & NECK
- ☐Neck for soft tissue
- ☐Skull
- ☐Sinuses
- ☐Facial bones
- ☐Nose
- ☐Orbits

CHEST
- ☐AP & LAT
- ☐Ribs RT LT Bll

SPINE AND PELVIS
- ☐Cervicalspine
- ☐Thoracic
- ☐Lumbar
- ☐Pelvis

UPPER EXTREMITIES
- ☐R or ☐L Elbow
- ☐R or ☐L Forearm
- ☐R or ☐L Shoulder
- ☐R or ☐L Humerus
- ☐R or ☐L Clavicle
- ☐R or ☐L Scapula
- ☐R or ☐L Wrist
- ☐R or ☐L Hand
- ☐R or ☐L Finger (digit)____

LOWER EXTREMITIES
- ☐R or ☐L Hip
- ☐R or ☐L Femur
- ☐R or ☐L Knee
- ☐R or ☐L Tib/Fib
- ☐R or ☐L Ankle
- ☐R or ☐L Foot
- ☐R or ☐L Heel
- ☐R or ☐L Toe (digit)____

Pregnacy Form:

I declare, to the best of my knowledge that I am not presently pregnant.

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Signature of patients