



Outpatient Imaging Order

Fax to: 207-618-8055

To: Coastal Imaging

From: _____

Date: _____

This fax represents a written order for diagnostic ultrasound testing. Please keep in mind when ordering tests, select only those which are medically necessary. Federal Law requires you to provide signs/symptoms pertaining to the procedures requested. "Rule out" will not be accepted.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Insurance Company Name: _____ Group Number: _____

Insurance Company Address: _____

Certificate Holder's Name: _____ Certificate Number: _____

Coastal Imaging cannot accept patients covered by the following plans: Medicare, MaineCare or TriCare.

Ordering Provider _____

Ordering Phone _____ Ordering Fax _____

ICD - 9 Code: _____ Clinical Indications: _____

Imaging Order Details:

- AAA Diagnostic
- AAA Screening
- Abdomen - Complete
- Abdomen - Limited
- Breast
- Carotid
- Lower Extremity
- OB - Under 20 Weeks Gestation
- Pelvic
- Renal
- Right Upper Quadrant
- Scrotal
- Spleen
- Thyroid
- Lower Extremity

Other Details: