K & T Diagnostic, Inc.
K & T Portable X-Ray Solutions
Phone: 800-909-5954 Fax: 833-815-2753
info@kandtdiagnostic.com
www.kandtdiagnostic.com

Patient's Name _____

Address _____

Phone # (_____) _____-_____ **Ins. Information** _____

Date of Birth _____/_____/_____

☐ **STAT**

******** **ULTRASOUND / CARDIOVASCULAR IMAGING / HOLTER MONITORING** ********

Each procedure will take on average between 30 and 40 minutes

☐ ARTERIAL LOWER BILATERAL WITH ABI	☐ ECHOCARDIOGRAPHY	
☐ ARTERIAL LOWER UNILATERAL WITH ABI	☐ ABDOMINAL COMPLETE WITH AORTA	(NPO 8 hours)
☐ ARTERIAL UPPER BILATERAL	☐ ABDOMINAL COMPLETE WITH RENAL (RI)	(NPO 8 hour)
☐ ARTERIAL UPPER UNILATERAL	☐ URINARY BLADDER WITH RENAL INDEX (RI)	(32oz of water prior)
☐ VENOUS LOWER BILATERAL	☐ PELVIC COMPLETE (M / F)	(32oz of water prior)
☐ VENOUS LOWER UNILATERAL	☐ THYROID EVALUATION	
☐ VENOUS UPPER BILATERAL	☐ SCROTUM & CONTENTS	
☐ VENOUS UPPER UNILATERAL	☐ SOFT TISSUE EVALUATION	
☐ CAROTID DUPLEX	☐ HOLTER MONITORING (48 HOURS)	

DIAGNOSIS (ICD-10)

Dx: _____

☐ **STAT** ******** **PORTABLE X-RAY / EKG / OCCUPATIONAL HEALTH** ********

Reason for Portable X-Ray: The Patient lives in Assisted Living Facility, Convalescent Hospital, or the patient is homebound and cannot be transported. Other: _____

☐ X-RAY ☐ B READER (PNEUMOCONIOSIS) ☐ EKG

Area of Body to X-Ray: _____ NUMBER OF VIEWS OF AREA: _____

☐ Complete ("Complete" will suffice if standard views are appropriate)

DIAGNOSIS (ICD-10)

Dx: _____

Physicians Name: _____ **NPI#** _____

Signature: _____ **Date:** _____/_____/_____

I certify, that I have examined the patient and the diagnostic procedure is necessary and the services will be furnished while the patient is under my care and that the plan is established and will be reviewed every 30 days or more often, if the patient's condition requires. Medical records will be available upon request.