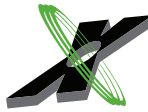


X-Ray X-Press
AN ADVANCED DIAGNOSTICS CO.



8305 Knight Road, Houston, Texas 77054
Phone: 713.790.0467 Fax: 713.383.4445

HOME HEALTH REQUEST
(All applicable items MUST be filled out)

Patient Name: _____ Date of Request: _____

Patient Phone #: _____ Alt. Phone #: _____

Is this a personal residence? _____

Exam Address: _____ Zip Code: _____

Is there a gate code? _____

same as exam address location

Home Address: _____ Zip Code: _____

Patient DOB: _____ Patient SSN: _____

[attach copy of front & back of pt. insurance card(s) or fill out information below]

Primary Ins: _____ ID #: _____ Group #: _____

Primary Ins Address & Phone: _____

Secondary Ins: _____ ID #: _____ Group #: _____

Secondary Ins Address & Phone: _____

Home Health Agency: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____

Ordering Physician: _____

Phone #: _____ Fax #: _____

Exam Ordered: _____ **Diagnosis:** _____

Physician's Signature: _____

Or Nurse's Signature (indicating verbal order): _____

Pre-Scheduling Criteria (circle yes or no): (only for non-facility locations)

Who is the primary contact for the patient on the day of the exam? Name: _____ Phone #: _____

Is patient located on a first floor? Yes No

If no, is there an elevator available?* Yes No

Does patient weigh less than 300 lbs.? Yes No

Would patient need assistance for exam? Yes No

Will someone who can help patient assist be present at time of exam? Yes No

Is there anything the techs should be aware of upon arrival? (i.e. dogs) _____

*Note: If there is no access available, we may not be able to accommodate upper floors.

Please fax completed form 713.383.4445. We will contact the patient to schedule the exam.

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