Your Hospital's Logo Here

OUTPATIENT DIAGNOSTIC SERVICES REQUEST FORM

TO BE COMPLETED BY HOSPITAL

PATIENT NAME:	DATE:	DOB:
ADDRESS: (Street) (City) (State) (Zip)		
ENCOUNTER #:	MED REC #:	SOCIAL SECURITY #:

TO BE COMPLETED BY REFERRING PHYSICIAN

DIAGNOSISES / PROCEDURE RATIONALE:
1. 2. 3. 4.

MD SIGNATURE:	MD PRINTED NAME:	DATE:	☐ Preadmission Testing ☐ Outpatient Testing (MUST schedule w/ each Department)

THIS WILL INTRODUCE _____ (PATIENT NAME) WHO IS BEING REFERRED FOR THE FOLLOWING PROCEDURES

SPECIAL INSTRUCTIONS / ORDERS:

TESTS MARKED WITH ASTERISK (*) REQUIRE ADVANCE APPOINTMENT

DIAGNOSTIC RADIOLOGY

HOURS OF SERVICE
M - F 8AM - 4:30PM
SAT 8:30AM - 12Noon

Appointments may be made M - F, from 8:30AM to 4:30PM, at:

MAMMOGRAPHY
(202) 555 - 1212
- *or* -
ALL OTHER STUDIES
(202) 555 - 1212

CHEST
- ☐ Chest, Pa & Lat
- ☐ Rib(s)

ABDOMEN
- ☐ AP (KUB)
- ☐ Abd, Multi Views

HEAD
- ☐ Mandible
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Orbits
- ☐ Sinuses
- ☐ Skull

C.T. SCAN *
- ☐ _____ (Specify Body Part)

SPINE / PELVIS
- ☐ C. Spine
- ☐ T. Spine
- ☐ L-S Spine
- ☐ Pelvis, AP

UPPER EXTREMITIES
- ☐ Shoulder
- ☐ Humerus (Arm)
- ☐ Elbow
- ☐ Forearm
- ☐ Wrists
- ☐ Hand

M.R.I. *
- ☐ _____ (Specify Body Part)

LOWER EXTREMITIES
- ☐ Hip(s)
- ☐ Femur (Thigh)
- ☐ Knee
- ☐ Tibia & Fibula (Leg)
- ☐ Ankle
- ☐ Foot

GASTROINTESTINAL*
- ☐ Esophagus *
- ☐ UGI *
- ☐ Small Bowel *
- ☐ B.E. w/ Air *
- ☐ B.E.
- ☐ G.B. *
- ☐ Swallowing Ability *

GENITOURINARY
- ☐ IVP *

APPT DATE _____
APPT DATE _____

MAMMOGRAPHY *
- ☐ Unilateral (Tailored) *
- ☐ Bilateral (Tailored) *
- ☐ Screening *

ARTHROGRAPHY
- ☐ _____ (Specify Joint)
- ☐ _____ (Specify Joint)

ULTRASOUND *
- ☐ Adb *
- ☐ Pelvic (O.B.) *
- ☐ Pelvic (Non O.B.) *

OTHER _____
OTHER _____
OTHER _____
TIME _____
TIME _____
TIME _____

EXAM(S) _____
EXAM(S) _____
EXAM(S) _____

DIAGNOSTIC CLINICAL LAB

HOURS OF SERVICE
M - F 8:00AM - 4:30PM
SAT 8:30AM - 12Noon
(202) 555 - 1212

- ☐ CBC
- ☐ Routine Urinalysis
- ☐ Protime
- ☐ PTT
- ☐ Bun
- ☐ SMA 6
- ☐ SMA 7
- ☐ Electrolytes
- ☐ Chemistry Profile 12
- ☐ Type & Rh
- ☐ Lipid Profile (Chol; Trig; HDLC)
- ☐ Glucose Tolerance *
- ☐ Other _____
- ☐ Other _____

CARDIOLOGY

(202) 555 - 1212

- ☐ ECG
- ☐ EEG *
- ☐ 24 Hr Holter Monitoring
- ☐ OTHER (Describe Below): _____

APPOINTMENT REQUIRED FOR ALL SERVICES BELOW

NUCLEAR MEDICINE

(202) 555 - 1212

BONE IMAGING
- ☐ Total Body
- ☐ SPECT: Area _____
- ☐ 3 Phase: Area _____
- ☐ Gallium Imaging

- ☐ Liver-Spleen Imaging
- ☐ SPECT Liver-Spleen
- ☐ Hemangioma-Liver
- ☐ Hepatobiliary Imaging (HIDA)
- ☐ GI Bleeding Study

CARDIAC STUDIES
- ☐ Thallium 201 ___ Stress ___ Rest
- ☐ Wall Motion (MUGA) ___ Stress ___ Rest

- ☐ Thyroid - Imaging & Uptake
- ☐ Renogram - Kidney Imaging
- ☐ Lung Imaging
- ☐ Indium - WBC Imaging
- ☐ Other

REHABILITATIVE SERVICES

(202) 555 - 1212

- ☐ Physical Therapy
- ☐ Audiology Screening
- ☐ Occupational Therapy
- ☐ Speech & Language Therapy
- ☐ Other

FREQUENCY _____

VASCULAR

(202) 555 - 1212

- ☐ Lower Extremity Arterial
- ☐ Venous Flow Patterns
- ☐ Carotid Duplex Scan
- ☐ Upper Extremity Arterial
- ☐ Quant Venous Flow Study
- ☐ Venous 3-Scan/Lower Extr
- ☐ Impedance Study
- ☐ OPG Study

PULMONARY

(202) 555 - 1212

- ☐ Spirometry Baseline
- ☐ Spirometry a&p Bronchodilator
- ☐ Full Lung Volumes
- ☐ Diffusion Capacity
- ☐ Other _____
- ☐ Other _____

OBSTETRICS

Phone (202) 555 - 1212
Phone (202) 555 - 1212

- ☐ Non-Stress Test
- ☐ Oxycotin Challenge Test

Phone (202) 555 - 1212
Phone (202) 555 - 1212

- ☐ BSST
- ☐ Biophysical Profile

NUTRITION

(202) 555 - 1212

- ☐ Diet Instructions (1st Visit) _____
- ☐ Diet Instructions (Follow Up Visit)_____
- ☐ Comp Nut. Analysis
- ☐ Other

FILE WITH OUTPATIENT MEDICAL RECORD

PART OF THE MEDICAL RECORD

To the Patient:

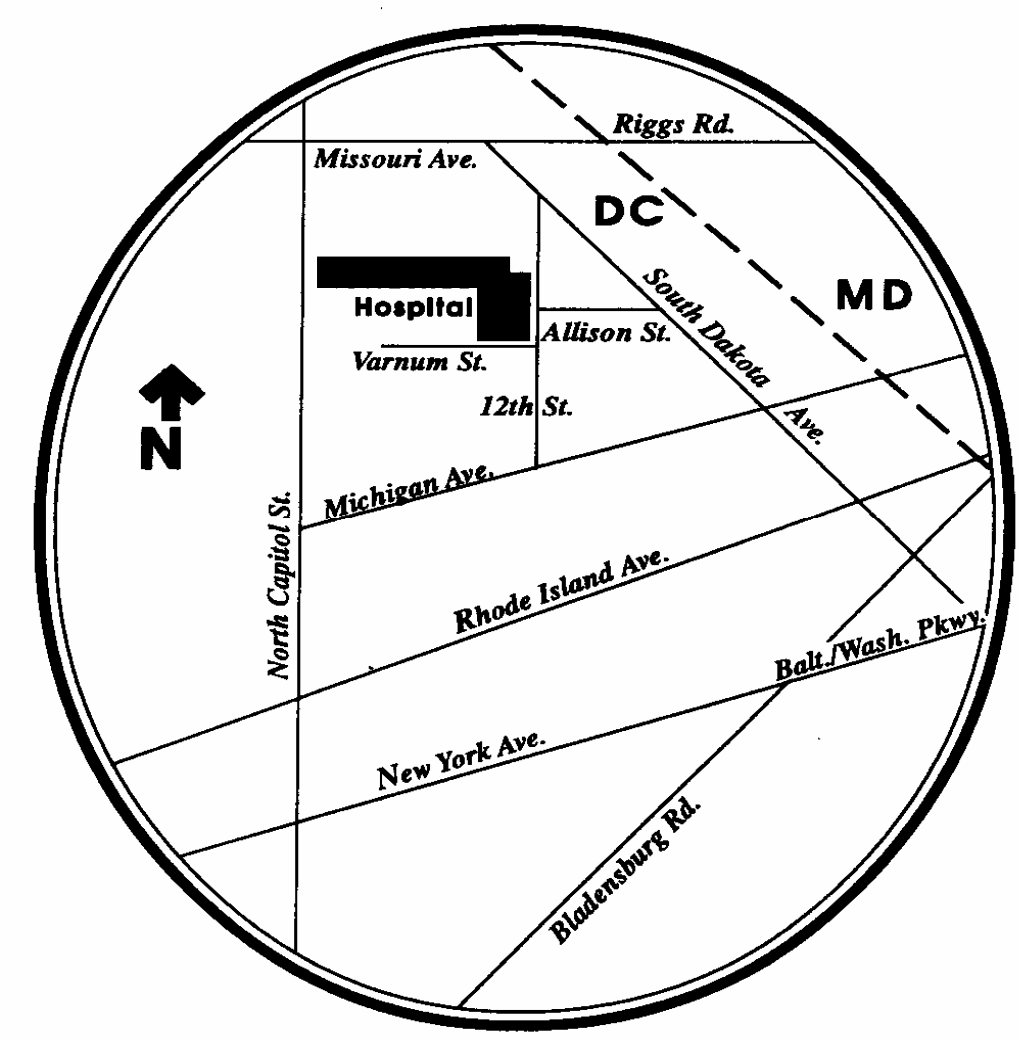
Please Bring

1. Insurance Cards and Forms
2. Positive Identification
3. Certification from Insurance Company (if required)
4. This Form

Before services can be performed, patient must bring this completed form to the outpatient registration area of the Hospital. Outpatient services cannot be rendered if this form is incomplete or if you do not have the required documentation. Many patients are enrolled in BLUE CROSS or have some form of group hospital insurance. Please read your contract carefully, so that you will know what coverage your insurance provides.

ROUTINE examinations will not be covered by Medicare or Medicaid and payment will be the responsibility of the patient. If you have received an Authorization Form for services, please bring it with you. Remember to bring your insurance membership card with you when you arrive. Patients eligible for Medicare, Medicaid or other insurance must present a valid membership card.

Your Doctor will receive reports of your studies.



PART OF THE MEDICAL RECORD