

Request for Outpatient Services



15103 N. Pennsylvania Avenue, Edmond, Oklahoma 73013
Phone: 405-251-2300 | Fax: 405-767-0913

Patient Information

Last Name _____ **First Name** _____ **Middle Name** _____

Date of Birth _____ **Primary Phone Number** _____

Name of Insurance Provider/ Policy # _____

Pre-Certification: Not Required In Progress Completed **Pre-Cert/Authorization#** _____

Reason for Test

REASON FOR THE TEST MUST BE GIVEN. (Please DO NOT USE "Rule Out" or "Possible/Probable?")

- ICD codes AND diagnostic information must be provided for EACH test ordered.

Outpatient Testing or Procedure Order

Reason/Diagnosis _____

ICD Code(s) _____

Order/ Results *Orders are valid for 90 days.

Requested Test Date: _____ ROUTINE at patient's convenience URGENT w/in 48 hours STAT

Results: Fax results _____ Call results _____ Hold patient for results & give images

X-Ray	<input type="checkbox"/> Other (specify): _____
CT	<input type="checkbox"/> Head/Brain <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Oral Contrast <input type="checkbox"/> Sinus <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> W/ IV Contrast <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thoracic Spine (<input type="checkbox"/> L) (<input type="checkbox"/> R) (<input type="checkbox"/> Bilat.) <input type="checkbox"/> W/O Contrast <input type="checkbox"/> Extremity (specify): _____ (<input type="checkbox"/> Upper) (<input type="checkbox"/> Lower) <input type="checkbox"/> W/ and W/O IV Contrast <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
MRI	<input type="checkbox"/> Carotid MRA <input type="checkbox"/> Brain MRI <input type="checkbox"/> Pelvis <input type="checkbox"/> Coccyx <input type="checkbox"/> W/O Contrast <input type="checkbox"/> Brain MRA <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Sacrum <input type="checkbox"/> IACs <input type="checkbox"/> W/ and W/O IV Contrast <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Foot L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Orbits <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> if claustrophobic <input type="checkbox"/> Upper Arm Non-Joint L / R <input type="checkbox"/> Lower Arm Non-Joint L / R <input type="checkbox"/> Upper Leg Non-Joint L / R <input type="checkbox"/> Lower Leg Non-Joint L / R <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
Ultrasound	<input type="checkbox"/> Abdomen (specify): (<input type="checkbox"/> Liver) (<input type="checkbox"/> Kidneys) (<input type="checkbox"/> MRCP) <input type="checkbox"/> Other (specify): _____

Physician Information

Referring Practitioner: _____ **Last Name** _____ **First Name** _____ **NPI #** _____

Practitioner's Phone Number _____ **Practitioner's Fax Number** _____

Practitioner's Signature _____ **Date** _____

Notice: Oklahoma ER & Hospital is unable to bill Medicare, Medicaid for services rendered.

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