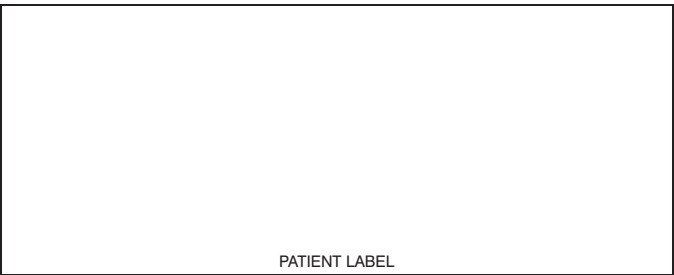


## OUTPATIENT TESTING ORDER

PLEASE PRINT CLEARLY



PATIENT LABEL

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_-\_\_\_\_-\_\_\_\_  
Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_  
PCP \_\_\_\_\_  
Primary Insurance \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_  
Patient Location Preference \_\_\_\_\_ AM / PM

**PHYSICAL MEDICINE**

Audiology  
 Cast Room  
 Occupational  
 Physical Therapy  
 Speech  
 EEG w/ Sedation  
 Transcranial Doppler  
 EMG (What Extremities) \_\_\_\_\_  
Equipment (specify) \_\_\_\_\_  
 Other Test \_\_\_\_\_  
Referral/Percent # \_\_\_\_\_  
Effective Date: From \_\_\_\_\_ To \_\_\_\_\_  
# of Visits Authorized \_\_\_\_\_

**CARDIOPULMONARY AND HAMOT HEART INSTITUTE**

Arterial Blood Gas  
 On Room Air  
 On Oxygen  
 Pulmonary Studies  
 Regular  Complete  CLCO (Diffusion Lung capacity)  
 Holter Monitor (24 Hr)  
 Echocardiography  
 Tilt Table  
 Pharmacological Stress Test  
 Regular Stress Test  
 Thallium Stress Test  
 EKG (ECG)  
 Sleep Study  CPAP Titration  
 Other Test \_\_\_\_\_  
Referral/Percent # \_\_\_\_\_

**MEDICAL NECESSITY**

A. Symptoms/Diagnosis \_\_\_\_\_  
ICD-9 Code(s) \_\_\_\_\_  
B. Purpose of Test \_\_\_\_\_  
CPT Code(s) \_\_\_\_\_  
C. Comments \_\_\_\_\_  
D.  No sedation Sedation:  IV  Oral  
E.  No contrast Contrast:  IV  PO  Rectal

Print Physician Name \_\_\_\_\_  
X \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
X \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

**RADIOLOGY**

CT with contrast \_\_\_\_\_  
CT without contrast \_\_\_\_\_  
Ultrasound of \_\_\_\_\_  
MRI of \_\_\_\_\_  
MRA of \_\_\_\_\_  
Special Procedures \_\_\_\_\_  
Bone Density \_\_\_\_\_  
 IVP  Venous Doppler  
 BE  KUB  
 Upper GI  Cookie Swallow  
 Upper GI w/Small Bowel  Chest X-Ray  
 VCUG (Voiding Cysto Urethrogram)  
 Nuclear Medicine  
 Other Test  
 Referral/Precert # \_\_\_\_\_

Patient Weight/Height \_\_\_\_\_ lbs. / \_\_\_\_\_ in.  
Metals \_\_\_\_\_  
Previous Films \_\_\_\_\_ Surgery \_\_\_\_\_  
Contrast Allergies \_\_\_\_\_  
Lab: Bun \_\_\_\_\_ Creatinine \_\_\_\_\_  
Date Done \_\_\_\_\_

**MAMMOGRAM** \* MUST KNOW WHEN AND WHERE LAST TEST DONE:

Bilateral  Diagnostic  
 Right  Screening  
 Left  Spot

Location of Exam \_\_\_\_\_ Scheduled Date \_\_\_\_\_ Time \_\_\_\_\_  
Dr. Office Contact \_\_\_\_\_ FAX # \_\_\_\_\_ Phone # \_\_\_\_\_  
Copy to \_\_\_\_\_

COPS Phone # 814-877-6123 Fax # 814-877-5090  
Hamot Heart Institute (Diagnostic Center) Phone # 814-877-5900 Fax # 814-877-5933

