

Request for Outpatient Imaging Services

Patient Information

Last Name _____ First Name _____ Middle Name _____

Date of Birth ____/____/____ Primary Phone Number (____) ____-____

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 (____) ____-____ Call (____) ____-____

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

Physician Information

Last Name _____ First Name _____ NPI# _____

Phone (____) ____-____ Fax (____) ____-____

Signature _____ Date ____/____/____

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

PRIVACY/CONFIDENTIALITY NOTICE REGARDING PROTECTED HEALTH INFORMATION

This document contains protected health information that is privileged, confidential and/or otherwise exempt from and protected from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this information in error and that any review, dissemination, distribution, copying or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this document in error, please destroy it immediately.