

**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

X-RAY	☐ Other (specify): _____			
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain	☐ Neck (Soft Tissues)	☐ Pelvis	☐ Chest
	☐ Sinus	☐ Cervical Spine	☐ Chest	☐ Abdomen
	☐ Lumbar Spine	☐ Thoracic Spine	☐ L ☐ R ☐ Bilat.	
	☐ Extremity (specify): _____		☐ Upper	☐ Lower
	☐ Other (specify): _____		Creatinine: _____	GFR: _____ Date: _____
MRI ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Carotid MRA	☐ Brain MRI	☐ Pelvis	☐ Coccyx
	☐ Brain MRA	☐ Neck (Soft Tissues)	☐ Sacrum	☐ IACs
	☐ Lumbar Spine	☐ Cervical Spine	☐ Foot L/R	☐ Wrist L/R
	☐ Thoracic Spine	☐ Shoulder L/R	☐ Hand L/R	☐ Knee L/R
	☐ Orbits	☐ Elbow L/R	☐ Hip L/R	☐ Ankle L/R
	☐ If Claustrophobic	☐ Upper Arm Non-Joint L/R	☐ Lower Arm Non-Joint L/R	
		☐ Upper Leg Non-Joint L/R	☐ Lower Leg Non-Joint L/R	
	☐ Other (specify): _____		Creatinine: _____	GFR: _____ Date: _____
	☐ Abdomen (specify):	☐ Liver	☐ Kidneys	☐ MRCP
	ULTRASOUND	☐ Other (specify): _____		
ECHOCARDIOGRAM	☐ Stress Test	☐ Echocardiogram	☐ Other (specify): _____	

PHYSICIAN INFORMATION

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

Practitioner's Phone Number: _____ Practitioner's Fax Number: _____

Practitioner's Signature: _____ Date: _____

Notice: Archview 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.