



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	<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"/> Neck (Soft Tissues)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Chest
	<input type="checkbox"/> Sinus	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen
	<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"/> Extremity (specify): _____		<input type="checkbox"/> Upper <input type="checkbox"/> Lower	
	<input type="checkbox"/> Other (specify): _____	Creatinine: _____	GFR: _____	Date: _____
MRI <input type="checkbox"/> W/O Contrast <input type="checkbox"/> W/ and W/O IV Contrast	<input type="checkbox"/> Carotid MRA	<input type="checkbox"/> Brain MRI	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Coccyx
	<input type="checkbox"/> Brain MRA	<input type="checkbox"/> Neck (Soft Tissues)	<input type="checkbox"/> Sacrum	<input type="checkbox"/> IACs
	<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: _____
	<input type="checkbox"/> Abdomen (specify): _____	<input type="checkbox"/> Liver	<input type="checkbox"/> Kidneys	<input type="checkbox"/> MRCP
	<input type="checkbox"/> Other (specify): _____			
ULTRASOUND	<input type="checkbox"/> Other (specify): _____			
ECHOCARDIOGRAM	<input type="checkbox"/> Stress Test	<input type="checkbox"/> Echocardiogram	<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: Bayou City ER & Hospital is unable to bill Medicare, Medicaid for services rendered.