Request for Outpatient Services

	4701 Phoenix Avenue, Fort Smith, Arkansas 72903 Phone: 479-974-9403 | Fax: 479-974-9404

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.

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Outpatient Testing or Procedure Order

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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 _______________

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):			

Physician Information

____

Referring Practitioner: Last Name First Name NPI #

____

Practitioner's Phone Number Practitioner's Fax Number

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Practitioner's Signature Date

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

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