Request for Outpatient Services

	Alexandria Emergency Hospital 5900 Coliseum Blvd Alexandria, LA 71303 Phone 318-386-8110 Fax 318-386-8107

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.

- ICD codes AND diagnostic information must be provided for EACH test ordered.
- **Please DO NOT USE “Rule Out” or “Possible/Probable?”**

____

Outpatient Testing or Procedure Order

____

Reason/Diagnosis

____

ICD Code(s)

Order/ Results

Requested Test Date:

◯ ROUTINE at patient’s convenience ◯ URGENT w/in 48 hours ◯ STAT

Date: ________________________

- Orders are valid for 90 days.

Results: ◯ Fax results ___________________ ◯ Call results __________________

◯ Hold patient for results send images with patient

Physician Information

____

Referring Practitioner: Last Name First Name NPI #

____

Practitioner’s Phone Number Practitioner’s Fax Number

____

Practitioner’s Signature Date

Notice: Alexandria Emergency Hospital is unable to bill Medicare, Medicaid for services rendered.

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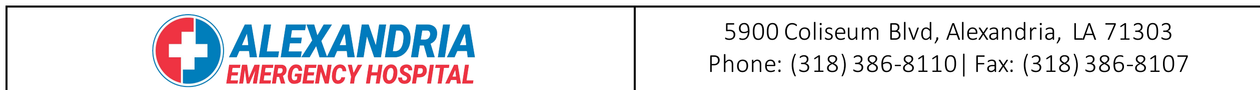
Request for Outpatient Services



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Results: ◯Fax results _____________ ◯Call results_____________ ◯Hold patient for results & give images

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 (< 6 weeks):_____GFR:_____ Date:_______ **If recent lab values are unavailable, we can perform at our facility.**
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 (< 6 weeks):_____GFR:_____ Date:_______ **If recent lab values are unavailable, we can perform at our facility.** ☐Abdomen (specify): (☐Liver) (☐Kidneys) (☐MRCP)
Ultrasound	☐Other (specify):

Physician Information

____

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