



Outpatient Services Request

2700 W Norfolk Ave Norfolk, NE 68701 (402) 371-4880
Central Scheduling Monday-Friday 7:30am - 5:00 pm (402) 644-7121
Fax (402) 844-8393

Today's Date	Appointment Date/Time	Physician	Patient Instruction: Please bring this form with you to the hospital registration desk.
Patient Name		Patient Birth Date	Patient Phone Number
Patient's Insurance Company	Preauth Required Yes or No	Preauth Number	Medicaid Yes or No

Medical Necessity (Signs/Symptoms/Reason for Service) *Must be completed

Cardiopulmonary / Vascular

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Lexiscan Cardiolyte | <input type="checkbox"/> Pseudo Aneurysm Evaluation | <input type="checkbox"/> Complete PFT | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Stress Cardiolyte | <input type="checkbox"/> Carotid Doppler | <input type="checkbox"/> PFT Screen | <input type="checkbox"/> Holter Monitor |
| <input type="checkbox"/> Dobutamine Echo | <input type="checkbox"/> Venous Insufficiency Study | <input type="checkbox"/> DLCO (Diffusion) | <input type="checkbox"/> 24 Hour <input type="checkbox"/> 48 Hour |
| <input type="checkbox"/> Stress Echo | <input type="checkbox"/> Arterial Doppler | <input type="checkbox"/> Oximetry w/ Exercise | <input type="checkbox"/> Event Monitor |
| <input type="checkbox"/> Tilt Table | <input type="checkbox"/> Ankle Brachial Index (ABI) | <input type="checkbox"/> On O2 <input type="checkbox"/> Off O2 | <input type="checkbox"/> Loop <input type="checkbox"/> Card |
| <input type="checkbox"/> TEE | <input type="checkbox"/> Venous Doppler | <input type="checkbox"/> Oximetry Overnight Trend | <input type="checkbox"/> Electroencephalogram (EEG) |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Arm <input type="checkbox"/> Leg | <input type="checkbox"/> On O2 <input type="checkbox"/> Off O2 | <input type="checkbox"/> Routine |
| <input type="checkbox"/> Bubble Study | <input type="checkbox"/> Bil <input type="checkbox"/> Right <input type="checkbox"/> Left | | <input type="checkbox"/> Sleep Deprived |
| | | | <input type="checkbox"/> One Hour |

Other:

Radiology

- | | | | | |
|---|---|--|--|---|
| <u>X-ray</u> | <u>CT</u> | <u>Contrast</u> <u>Angio</u> | <u>Contrast</u> | <u>Nuclear Medicine</u> |
| <input type="checkbox"/> Chest PA & Lateral | <input type="checkbox"/> Head | with without | with without | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Chest | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> HIDA |
| <input type="checkbox"/> Flat Plate <input type="checkbox"/> Series | <input type="checkbox"/> PE Protocol | <input type="checkbox"/> High Resolution | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> MUGA |
| <input type="checkbox"/> Upper GI | <input type="checkbox"/> Abdomen | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> Thyroid Uptake & Scan (I-123) |
| <input type="checkbox"/> Small Bowel Series | <input type="checkbox"/> Pelvis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Spine | |
| <input type="checkbox"/> Barium Swallow | <input type="checkbox"/> Appy Protocol <input type="checkbox"/> Kidney Stone Protocol | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Cervical | <input type="checkbox"/> <u>Ultrasound</u> |
| <input type="checkbox"/> Barium Enema | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Abdomen |
| | <input type="checkbox"/> Maxillofacial | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Lumbar | <input type="checkbox"/> Gallbladder Only |
| <u>Mammogram</u> | <input type="checkbox"/> Orbit/Ear | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | <input type="checkbox"/> AAA (recheck) |
| <input type="checkbox"/> Screening | <input type="checkbox"/> Spine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <u>MRA</u> | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Bil <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Cervical | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Thoracic | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Carotid | <input type="checkbox"/> Renal Artery |
| <input type="checkbox"/> Bil <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Lumbar | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> ABD Aorta | <input type="checkbox"/> Thyroid |
| | <input type="checkbox"/> 3D <input type="checkbox"/> Myelogram | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> ABD Renals | <input type="checkbox"/> Breast |
| | | | <input type="checkbox"/> Runoff | <input type="checkbox"/> Bil <input type="checkbox"/> Right <input type="checkbox"/> Left |

Other:

Other Ancillary Services:

Comments:

Send Duplicate Results To: _____ Address/Fax: _____

Authentication:

Ordering Physician Signature _____ Date _____

*Physician ordering test or Allied Health Practitioner acting within the scope of any license, certificate, or other legal credential authorizing practice in Nebraska

Order Clarification (Internal use only)

Date/Time _____ VOV/TOV by: _____ Signature / Date (Physician / AHP) _____

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Patient Label Optional