FAITH REGIONAL HEALTH SERVICES

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	Preauth Number	Medicaid
	Yes or No		Yes or No

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

Cardiopulmonary / Vascular

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

Other:

Radiology

X-ray
- ☐ Chest PA & Lateral
- ☐ Abdomen
  - ☐ Flat Plate ☐ Series
- ☐ Upper GI
- ☐ Small Bowel Series
- ☐ Barium Swallow
- ☐ Barium Enema

Mammogram
- ☐ Screening
  - ☐ Bil ☐ Right ☐ Left
- ☐ Diagnostic
  - ☐ Bil ☐ Right ☐ Left

CT (Contrast: with / without; Angio)
- ☐ Head — ☐ ☐ ☐
- ☐ Chest — ☐ ☐ ☐
  - ☐ PE Protocol ☐ High Resolution
- ☐ Abdomen — ☐ ☐ ☐
- ☐ Pelvis — ☐ ☐ ☐
  - ☐ Appy Protocol ☐ Kidney Stone Protocol
- ☐ Soft Tissue Neck — ☐ ☐
- ☐ Maxillofacial — ☐ ☐
- ☐ Orbit/Ear — ☐ ☐

Spine
- ☐ Cervical — ☐ ☐
- ☐ Thoracic — ☐ ☐
- ☐ Lumbar — ☐ ☐
  - ☐ 3D ☐ Myelogram

MRI (Contrast: with / without)
- ☐ Head — ☐ ☐
- ☐ Joint — ☐ ☐
  - ☐ Arthrogram

Spine
- ☐ Cervical — ☐ ☐
- ☐ Thoracic — ☐ ☐
- ☐ Lumbar — ☐ ☐

MRA
- ☐ Head — ☐ ☐
- ☐ Carotid — ☐ ☐
- ☐ ABD Aorta — ☐ ☐
- ☐ ABD Renals — ☐ ☐
- ☐ Runoff

Nuclear Medicine
- ☐ Bone Scan
- ☐ HIDA
- ☐ MUGA
- ☐ Thyroid Uptake & Scan (I-123)

Ultrasound
- ☐ Abdomen
- ☐ Gallbladder Only
- ☐ AAA (recheck)
- ☐ Pelvis
- ☐ Kidney
- ☐ Renal Artery
- ☐ Thyroid
- ☐ Breast
  - ☐ Bil ☐ Right ☐ Left

Other:

Other Ancillary Services:

Comments:

Send Duplicate Results To: _____ Address/Fax: _____

Authentication:

Ordering Physician Signature _____ Date _____

*Physician ordering test or Allied Heath 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)

Patient Label Optional