North Arkansas REGIONAL MEDICAL CENTER

OUTPATIENT ORDER FORM

**NOTE TO PHYSICIAN: This form is for outpatient services only. Do not use for outpatient surgery or admission orders.

PATIENT NAME: _____ D.O.B.: _____ PHONE#: _____ REQUIRED PRE-CERT #_____

DATE TO BE PERFORMED : _____ PHYSICIAN NAME: _____

**PROVISIONAL DIAGNOSIS: REQUIRED _____

**** PLEASE BRING A CURRENT LIST OF ALL YOUR MEDICATIONS ****

Medicare will only pay for items and services that it determines to be "Reasonable and Necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular item or service, although it would be otherwise covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that item or service. **Put "S" if screening. Advance Beneficiary Notice will be filled out by NARMC on tests not covered by Medicare.

RADIOLOGY 414-4085 Fax: 414-4912

_____ ACUTE ABDOMEN SERIES
_____ ABDOMEN 1 VIEW
_____ ABDOMEN 2 VIEWS
_____ CHEST
_____ Ba ENEMA
_____ INTRAVENOUS PYELOGRAM
_____ UGI
_____ SBFT
_____ ARTHROGRAM
_____ SKULL SERIES
_____ MYELOGRAM
_____ SPINE _____
_____ EXTREMITY_____
_____ OTHER: _____
_____

ULTRASOUND

_____ GB
_____ PELVIS
_____ TRANSVAGINAL
_____ ABDOMINAL SURVEY
_____ LIVER
_____ CAROTID DUPLEX
_____ LOWER EXTREMITY VENOUS
- UNILAT._____
- BILAT. _____
_____ ARTERIAL DUPLEX
- UNILAT._____
- BILAT. _____
_____ OB
_____ THYROID
_____ RENAL
_____ AORTA
_____ ABDOMEN LIMITED one organ quad
_____ OTHER: _____
_____

CT SCAN

_____ W / Cont
_____ WO/ Cont
_____ W & WO

_____ CHEST
_____ HEAD
_____ SINUSES
_____ SPINE
_____ ABDOMEN & PELVIS
_____ PELVIC
_____ IAC'S

_____ OTHER:_____
_____
_____

MAMMO 414-4207 Fax: 414-4917

_____ MAMMOGRAM
_____ DEXA: BONE MINERAL DENSITY

ECHO LAB 414-4085 Fax: 414-4912

_____ECHOCARDIOGRAM
_____STRESS ECHO

MRI 414-4207 Fax: 414-4917

_____ WO/ Cont
_____ W & WO

_____ MRI BRAIN
_____ MRI CERVICAL
_____ MRI DORSAL SPINE
_____ MRI KNEE
_____ MRI SHOULDER
_____ MRI LUMBAR
_____ MRI CAROTIDS
_____ MRA CIRCLE OF WILLIS
_____OTHER:_____
_____

NUCLEAR MEDICINE 414-4090

_____ BONE SCAN, Whole body, **SPEC, 3-Phase, LIMITED**
_____THYROID UPTAKE W/SCAN
_____ MUGA
_____ BILIARY SCAN
_____ RENOGRAM
_____ CYSTOGRAM
_____ CARDIOLITE STRESS, REST
_____PERSANTINE
_____DOBUTAMINE
_____VENTILATION & PERFUSION LUNG SCAN

RESPIRATORY THERAPY 414-4396 Fax: 414-4939

EEG: _____ ROUTINE _____ SLEEP DEPRIVED

ECG: _____ BASIC EKG _____ EKG W / WO MAGNET ____ ECG W / RHYTHM STRIP

SPECIMEN COLLECTION: _____ INDUCED SPUTUM INDUCTI
_____ ABG'S- specify FI02_____

PULMONARY FUNCTION TESTING: _____ BASIC _____ DLCO, _____ FRC,
_____ BRONCHODIALATOR RESPONSIVENESS
_____ M V V

PULSE OXIMETRY: _____SPOT CHECK_____HOME O2 QUALIFICATION

UPDRAFT: MEDICINE AND DOSAGE _____

VASCULAR LAB 414-4039 Fax: 414-4939

TREADMILL TESTING: ____BASIC TREADMILL ____NUCLEAR CARDIAC STRESS

HOLTER MONITOR: _____24HR _____ 48 HR OTHER _____

PHYSICAL THERAPY 414-5051 Fax: 414-5071

_____ PHYSICAL THERAPY EVALUATE AND TREAT
_____ OCCUPATIONAL THERAPY EVALUATE AND TREAT
_____ SPEECH THERAPY EVALUATE AND TREAT
_____
_____
_____ EMG_____
NCV_____

NUTRITION SERVICES MNT 414-4047 Fax: 414-4944

_____ DIABETIC DIET
_____ PRERENAL DIET
_____ OTHER DIET _____

PATIENT ID LABEL HERE

PHYSICIAN'S SIGNATURE _____

DATE _____