UPMC Hamot

OUTPATIENT TESTING ORDER

PLEASE PRINT CLEARLY

PATIENT LABEL

D.O.B. ____/____/____ SS # ____-____-____

Patient Name ____

Address ____

____

Phone: Home ____ Work ____

PCP ____

Primary Insurance ____

Secondary Insurance ____

Patient Location Preference ____ AM / PM

PHYSICAL MEDICINE

- ☐ Audiology
- ☐ Cast Room
- ☐ Occupational
- ☐ Physical Therapy
- ☐ Speech
- ☐ EEG w/ Sedation
- ☐ Transcranial Doppler
- ☐ EMG (What Extremities) ____

Equipment (specify) ____

- ☐ Other Test ____

Referral/Percent # ____

Effective Date: From ____ To ____

# of Visits Authorized ____

CARDIOPULMONARY AND HAMOT HEART INSTITUTE

- ☐ Arterial Blood Gas
  - ☐ On Room Air
  - ☐ On Oxygen
- ☐ Pulmonary Studies
  - ☐ Regular ☐ Complete ☐ CLCO (Diffusion Lung capacity)
- ☐ Holter Monitor (24 Hr)
- ☐ Echocardiography
- ☐ Tilt Table
- ☐ Pharmacological Stress Test
- ☐ Regular Stress Test
- ☐ Thallium Stress Test
- ☐ EKG (ECG)
- ☐ Sleep Study ☐ CPAP Titration
- ☐ Other Test ____

Referral/Percent # ____

MEDICAL NECESSITY

A. Symptoms/Diagnosis ____

____

ICD-9 Code(s) ____

B. Purpose of Test ____

CPT Code(s) ____

C. Comments ____

D. ☐ No sedation Sedation: ☐ IV ☐ Oral

E. ☐ No contrast Contrast: ☐ IV ☐ PO ☐ Rectal

Print Physician Name

X ____

Physician Signature Date: ____/____/____

X ____ Time: ____ AM / PM

RADIOLOGY

CT with contrast ____

CT without contrast ____

Ultrasound of ____

MRI of ____

MRA of ____

Special Procedures ____

Bone Density ____

- ☐ IVP
- ☐ BE
- ☐ Upper GI
- ☐ Upper GI w/Small Bowel
- ☐ VCUG (Voiding Cysto Urethragram)
- ☐ Nuclear Medicine
- ☐ Other Test
- ☐ Referral/Precert #
- ☐ Venous Doppler
- ☐ KUB
- ☐ Cookie Swallow
- ☐ Chest X-Ray

Patient Weight/Height ____ **lbs.** / ____ **in.**

Metals ____

Previous Films ____ **Surgery** ____

Contrast Allergies ____

Lab: Bun ____ **Creatinine** ____

Date Done ____

MAMMOGRAM ** MUST KNOW WHEN AND WHERE LAST TEST DONE:*

____

- ☐ Bilateral
- ☐ Right
- ☐ Left
- ☐ Diagnostic
- ☐ Screening
- ☐ Spot

Location of Exam ____ Scheduled Date ____ Time ____

Dr. Office Contact ____ FAX # ____ Phone # ____

Copy to ____

COPS Phone # 814-877-6123 Fax # 814-877-5090
Hamot Heart Institute (Diagnostic Center) Phone # 814-877-5900 Fax # 814-877-5933