



PHYSICIAN OUTPATIENT ORDER FORM

For Hospital Use Only

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|---|-------------|----------|
| <input type="checkbox"/> UNIVERSITY | FAX NUMBERS | 937-3333 |
| <input type="checkbox"/> GERMANTOWN | | 937-3334 |
| <input type="checkbox"/> Radiology & Mammography
Germantown Center | | 759-7510 |
| <input type="checkbox"/> LE BONHEUR | | 937-3335 |
| <input type="checkbox"/> NORTH | | 937-3337 |
| <input type="checkbox"/> SOUTH | | 937-3336 |
| <input type="checkbox"/> FAYETTE | | 465-7464 |

PATIENT INFORMATION:

LAST NAME (Required)

FIRST (Required)

M.I.

SEX PHONE #

SS# (Required)

DATE OF BIRTH (Required)

STREET ADDRESS

CITY

STATE

ZIP

CHIEF COMPLAINT / CLINICAL INFORMATION (Required) (Must Indicate Medical Necessity for **EACH SERVICE BEING REQUESTED** and any clinical information clarifying Medical Necessity)

Procedure(s) (Required) (Please Be Specific)	ICD9 or CPT	Pre-Cert Number(s)
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Insurance _____

Procedure Date	Sched. Time	Arrival time (if different than Sched. Time)
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Instructions to Patient (Complete **ONLY** if you wish to write specific instructions / preps to your patient)

ORDERING PHYSICIAN SIGNATURE (MUST be original signature — stamped signature not acceptable)

Physician Name (Printed)	Date of Signature

Physician Phone # _____ Office Address _____