

ORDER FOR OUTPATIENT SERVICES

Patient Name:	
Birth Date:	Social Security Number:
Date of Appointment:	Appointment Time:
Call Report To:	Phone Number to Call:

PERTINENT HISTORY/DIAGNOSIS/CLINICAL INDICATIONS FOR SERVICES ORDERED

For the clinic to bill properly and receive payment for tests you have ordered, it is critical that the diagnosis you provide is consistent with the information recorded in the patient's medical record and with any claim submitted by your office. The Department of Health and Human Services requires all tests ordered for Medicare beneficiaries be reasonable and necessary. If the diagnosis you provide does not support the medical necessity of the test ordered under Medicare program standards, Medicare will deny payment and the beneficiary may be financially responsible for the test.

ICD 9 Code(s)

Scheduling

	<p>To schedule an exam, please call 316.462.2000.</p>
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MRI	CT Scan	ULTRASOUND	Radiology
TMJs	Head/Brain	Echocardiography	Abdomen (KUB)
Orbit, Neck, Face	Orbits/IACs	Thyroid	Abdomen Series
Brain	Thorax/Chest	Chest	Ankle <input type="checkbox"/> L <input type="checkbox"/> R
Chest	Abdomen	Breast <input type="checkbox"/> L <input type="checkbox"/> R	Cervical Spine
Cervical Spine	Cervical Spine	Abdomen	Chest (PA & Lat)
Thoracic Spine	Thoracic Spine	Gallbladder	Clavicle <input type="checkbox"/> L <input type="checkbox"/> R
Lumbar Spine	Lumbar Spine	Liver	Elbow <input type="checkbox"/> L <input type="checkbox"/> R
Pelvis	Pelvis	Pancreas	Facial Bones
Joint, Specify: _____	Abd/Pelvis for kidney stone	Spleen	Femur <input type="checkbox"/> L <input type="checkbox"/> R
Upper extremity	Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Abdominal Aorta	Finger(s) <input type="checkbox"/> L <input type="checkbox"/> R
Lower Extremity	Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Renal <input type="checkbox"/> L <input type="checkbox"/> R	Foot <input type="checkbox"/> L <input type="checkbox"/> R
MR Arthrogram with Fluoro	Sinuses	OB	Forearm <input type="checkbox"/> L <input type="checkbox"/> R
Specify _____	Soft Tissue neck	OB (transvaginal)	Hand <input type="checkbox"/> L <input type="checkbox"/> R
Abdomen	CT Angiogram (CTA)	Biophysical Profile	Heel <input type="checkbox"/> L <input type="checkbox"/> R
Cardiac	Specify _____	Transvaginal	Hip(s) <input type="checkbox"/> L <input type="checkbox"/> R
MRA	Other	Pelvic (transvag, if indicated)	Hips, Bilateral & Pelvis
<i>Please include MRA form</i>	Fluoroscopy	Scrotum w Testicular Duplex	Humerus <input type="checkbox"/> L <input type="checkbox"/> R
MRA Lower Extremity (including distal abdominal aorta) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat	Arthrogram Specify _____	Extremity-Non Vascular	Knee <input type="checkbox"/> L <input type="checkbox"/> R
MRA, Specify: _____	Barium Enema	Carotid	Lumbar Spine
Other exams/instructions	Cystogram, Voiding	Arterial, Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Mandible
	Esophagus	Arterial, Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Metastatic Bone Survey
	Hysterosalpingogram	Venous, Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Nasal Bones
PET Scan	Pyelogram (IVP)	Venous, Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R	Optic Foramina
Diagnosis	Small Bowel	Other	Orbits
Reason	Upper GI Series		Pelvis
<input type="checkbox"/> Staging	Other		Ribs <input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Restaging			Sacroiliac Joints
<input type="checkbox"/> Diagnosis			Scapula <input type="checkbox"/> L <input type="checkbox"/> R
	DEXA/EKG		Shoulder <input type="checkbox"/> L <input type="checkbox"/> R
	DEXA		Sinuses
	EKG		Skull
Mammography			Sternum
Screening (diagnostic and/or ultrasound if indicated)		Implants (?)	Thoracic Spine
Diagnostic (ultrasound if indicated) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat		<input type="checkbox"/> Nipple Discharge	Tibia/Fibula <input type="checkbox"/> L <input type="checkbox"/> R
Breast Core Biopsy with Ultrasound <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat		<input type="checkbox"/> Inverted Nipple	Toes <input type="checkbox"/> L <input type="checkbox"/> R
Ductogram <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat		<input type="checkbox"/> Lump or Mass / Location _____	Wrist <input type="checkbox"/> L <input type="checkbox"/> R
Other		<input type="checkbox"/> Pain	Other
		<input type="checkbox"/> Personal history of CA	

PLEASE FAX OR HAVE PATIENT BRING COMPLETED ORDER SHEET WITH THEM TO THEIR APPOINTMENT

Signature Required

Ordering Physician Signature	Completed by (print name)
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