

# Request for Outpatient Services



9310 Coors Blvd NW, Albuquerque, NM 87114  
Phone: (505) 431-1900 | Fax: (505) 431-1902

## Patient Information

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Primary Phone Number** \_\_\_\_\_

**Name of Insurance Provider/ Policy #** \_\_\_\_\_

**Pre-Certification:**  Not Required  In Progress  Completed **Pre-Cert/Authorization#** \_\_\_\_\_

## Reason for Test

**REASON FOR THE TEST MUST BE GIVEN. (Please DO NOT USE "Rule Out" or "Possible/Probable?")**

- ICD codes AND diagnostic information must be provided for EACH test ordered.

## Outpatient Testing or Procedure Order

**Reason/Diagnosis** \_\_\_\_\_

**ICD Code(s)** \_\_\_\_\_

**Order/ Results** \*Orders are valid for 90 days.

**Requested Test Date:** \_\_\_\_\_  ROUTINE at patient's convenience  URGENT w/in 48 hours  STAT

**Results:**  Fax results \_\_\_\_\_  Call results \_\_\_\_\_  Hold patient for results & give images

<b>X-Ray</b>	<input type="checkbox"/> Other (specify): _____
<b>CT</b>	<input type="checkbox"/> Head/Brain <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Sinus <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thoracic Spine    ( <input type="checkbox"/> L ) ( <input type="checkbox"/> R ) ( <input type="checkbox"/> Bilat. ) <input type="checkbox"/> Extremity (specify): _____ ( <input type="checkbox"/> Upper ) ( <input type="checkbox"/> Lower ) <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
<input type="checkbox"/> Oral Contrast <input type="checkbox"/> W/ IV Contrast <input type="checkbox"/> W/O Contrast <input type="checkbox"/> W/ and W/O IV Contrast	
<b>MRI</b>	<input type="checkbox"/> Carotid MRA <input type="checkbox"/> Brain MRI <input type="checkbox"/> Pelvis <input type="checkbox"/> Coccyx <input type="checkbox"/> Brain MRA <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Sacrum <input type="checkbox"/> IACs <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Foot L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Orbits <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> if claustrophobic <input type="checkbox"/> Upper Arm Non-Joint L / R <input type="checkbox"/> Lower Arm Non-Joint L / R <input type="checkbox"/> Upper Leg Non-Joint L / R <input type="checkbox"/> Lower Leg Non-Joint L / R <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
<input type="checkbox"/> W/O Contrast <input type="checkbox"/> W/ and W/O IV Contrast	
	<input type="checkbox"/> Abdomen (specify): ( <input type="checkbox"/> Liver ) ( <input type="checkbox"/> Kidneys ) ( <input type="checkbox"/> MRCP )
<b>Ultrasound</b>	<input type="checkbox"/> Other (specify): _____

## Physician Information

**Referring Practitioner:** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **NPI #** \_\_\_\_\_

**Practitioner's Phone Number** \_\_\_\_\_ **Practitioner's Fax Number** \_\_\_\_\_

**Practitioner's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Notice: Albuquerque ER & Hospital is unable to bill Medicare, Medicaid for services rendered.**

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