

**ALBUQUERQUE
ER & HOSPITAL**

REQUEST FOR OUTPATIENT SERVICES

ALBUQUERQUE ER & HOSPITAL - WEST
9310 Coors Blvd NW, Albuquerque, NM 87114
Phone: 505-431-1900 • Fax: 505-431-1902

ALBUQUERQUE ER & HOSPITAL - EAST
8220 Montgomery NE, Albuquerque, NM 87109
Phone: 505-532-0062 • Fax: 505-585-0142

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

X-RAY	☐ Other (specify): _____			
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain	☐ Neck (Soft Tissues)	☐ Low-Dose Chest	☐ Chest
	☐ Sinus	☐ Cervical Spine	☐ Pelvis	☐ Abdomen
	☐ Lumbar Spine	☐ Thoracic Spine	☐ L ☐ R ☐ Bilat.	
	☐ Extremity (specify): _____		☐ Upper ☐ Lower	
	☐ Other (specify): _____	Creatinine: _____	GFR: _____	Date: _____
MRI ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Carotid MRA	☐ Brain MRI	☐ Pelvis	☐ Coccyx
	☐ Brain MRA	☐ Neck (Soft Tissues)	☐ Sacrum	☐ IACs
	☐ Lumbar Spine	☐ Cervical Spine	☐ Foot L/R	☐ Wrist L/R
	☐ Thoracic Spine	☐ Shoulder L/R	☐ Hand L/R	☐ Knee L/R
	☐ Orbits	☐ Elbow L/R	☐ Hip L/R	☐ Ankle L/R
☐ Legal Drug Testing (East Location Only)	☐ If Claustrophobic	☐ Upper Arm Non-Joint L/R	☐ Lower Arm Non-Joint L/R	
	☐ Upper Leg Non-Joint L/R	☐ Lower Leg Non-Joint L/R		
	☐ Other (specify): _____	Creatinine: _____	GFR: _____	Date: _____
	☐ Abdomen (specify): _____	☐ Liver	☐ Kidneys	☐ MRCP
ULTRASOUND	☐ Other (specify): _____			
EKG	☐ 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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