Request for Outpatient Services

ROYSE CITY EMERGENCY HOSPITAL	890 S Erby Campbell Blvd, Royse City, TX 75189 P:469-981-9604

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 _____

X-Ray	☐ Other (specify):
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain ☐ Neck (Soft Tissues) ☐ Pelvis ☐ Chest ☐ Sinus ☐ Cervical Spine ☐ Chest ☐ 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 ☐ 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):

Physician Information

Referring Practitioner: Last Name First Name NPI #

Practitioner's Phone Number Practitioner's Fax Number

Practitioner's Signature Date

Notice: Royse City Emergency Hospital is unable to bill Medicare, Medicaid for services rendered.