


Request for Outpatient Services

 <b style="font-size: 1.2em; color: #0070C0;">ROYSE CITY <b style="color: #D9534F;">EMERGENCY HOSPITAL	890 S Erby Campbell Blvd, Royse City, TX 75189 P:469-981-9604
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Patient Information

Last Name	First Name	Middle Name
Date of Birth	Primary Phone Number	
Name of Insurance Provider/ Policy # _____		
Pre-Certification: <input type="radio"/> Not Required <input type="radio"/> In Progress <input type="radio"/> 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	<input type="checkbox"/> Other (specify): _____	
CT <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	<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: _____	
	MRI <input type="checkbox"/> W/O Contrast <input type="checkbox"/> W/ and W/O IV Contrast	<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"/> Abdomen (specify): (<input type="checkbox"/> Liver) (<input type="checkbox"/> Kidneys) (<input type="checkbox"/> MRCP)
	Ultrasound	<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: Royse City Emergency Hospital is unable to bill Medicare, Medicaid for services rendered.

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