Outpatient Services Request

2700 W Norfolk Ave Norfolk, NE 68701 (402) 371-4880

Central Scheduling Monday-Friday 7:30am - 5pm **Phone: (402) 644-7121 Fax: (888) 779-4704**

* Outpatient orders must be faxed **before** calling to schedule same day or next day appointments. For appointments scheduled further out, orders will need to be faxed as soon as possible (no later than end of day).

Today's' Date:	Appointment Date/Time:	Physician:	Patient Instruction: Please bring this form to the hospital registration desk.
Patient Name:		Patient Date of Birth:	Patient Phone Number:
Patient's Insurance Company; Prior Auth Required? Yes No		Preauth Number:	Medicaid: Yes No
Medical Necessity (Signs/Symptoms/Reason for Service): (Required information)			

Cardiopulmonary/Vascular Procedures:

☐	Lexiscan Cardiolyte	☐	Pseudo Aneurysm Evaluation	☐	Complete PFT	☐	EKG
☐	Stress Cardiolyte	☐	Carotid Doppler	☐	PFT Screen	☐	Holter Monitor
☐	Dobutamine Echo	☐	Venous Insufficiency Study	☐	DLCO (Diffusion)		☐ 24-Hour ☐ 48-Hour
☐	Stress Echo	☐	Venous Ablation	☐	MOB pre/post	☐	Event Monitor
☐	Tilt Table	☐	Arterial Doppler	☐	Methacholine Challenge		☐ Loop ☐ Card
☐	Treadmill	☐	Ankle Brachial Index (ABI)		☐ with PFT ☐ w/o PFT	☐	Electroencephalogram (EEG)
☐	TEE	☐	Venous Doppler	☐	Oximetry w/ Exercise		☐ Routine
☐	Echocardiogram		☐ Arm ☐ Leg		☐ On O2 ☐ Off O2		☐ Sleep Deprived
☐	Bubble Study		☐ Right ☐ Left ☐ Bilateral	☐	Oximetry Overnight Trend		☐ One Hour
☐	Other:				☐ On O2 ☐ Off O2		☐ With Sedation

Radiology Exams/Procedures:

X-Ray/Diagnostic	
☐	Chest Front & Lateral
☐	Abdomen ☐ Pelvis
☐	Upper GI ☐ KUB ☐ Bowel
☐	Spine ☐ C ☐ T ☐ L
☐	Shoulder ☐ Arthrogram
	☐Elbow☐Forearm☐Wrist☐Finger
	☐Knee☐Femur☐Ankle☐Foot
	☐ Bilateral ☐ Right ☐ Left

Mammogram	
☐	Screening
☐	Diagnostic
	☐ Bilateral ☐ Right ☐ Left

Nuclear Medicine	
☐	Bone Scan
☐	HIDA
☐	MUGA
☐	Thyoid Uptake & Scan (I-123)

	CT Scan	Contrast With	W/Out
☐	Head	☐	☐
☐	Chest	☐	☐
	☐ PE Protocol	☐	☐
☐	Abdomen	☐	☐
☐	Pelvis	☐	☐
	☐ Appy Protocol ☐ Kidney Stone Protocol		
☐	Soft Tissue Neck	☐	☐
☐	Maxillofacial	☐	☐
☐	Orbit/Ear	☐	☐
☐	Spine ☐ Myelogram	☐	☐
	☐Cervical ☐Thoracic ☐Lumbar		

	CT Angiogram	Contrast
☐	Carotid	With
☐	Circle of Willis	With
☐	ABD Aorta ☐ Runoff	With
☐	Upper Extremity (Runoff)	With
☐	Lower Extremity (Runoff)	With
	☐ Bilateral ☐ Right ☐ Left	
☐	3D Reconstruction	

	MRI	Contrast
☐	Head	☐ WithOut ☐ With/Wout
☐	Joint	Without
☐	Arthrogram	With
☐	Pelvis	☐ WithOut ☐ With/Wout
☐	Spine	☐ WithOut ☐ With/Wout
	☐Cervical ☐Thoracic ☐Lumbar	

	MRA	Contrast
☐	Head	Without
☐	Carotid	With & Without
☐	Abdomenal Aorta	With & Without
☐	Abdomenal Renals	With & Without
☐	Upper Extremity (Runoff)	With & Without
☐	Lower Extremity (Runoff)	With & Without
	☐ Bilateral ☐ Right ☐ Left	

Ultrasound			
☐	Abdomen	☐	Renal Artery Doppler
☐	ABD Limited/Quadrant	☐	Thyroid
☐	AAA	☐	Breast
☐	Pelvis		☐ Bilateral ☐ Right ☐ Left
☐	Kidney/Renal		

☐ Other:

Comments:		Results to be Communicated by: ☐ Call ☐ Mail ☐ Visit	
Send Duplicate Results to:		Address/Fax:	
Ordering Provider Signature:	Send Emergency Results via: Phone: ____________ Pager: ____________	Date:	*Physician or Allied Health Practitioner acting within the scope of license, certificate, or other legal credential authorizing practice in Nebraska
Order Clarification (internal use only):			
Date/Time:	TOV/VOV by:	Provider Co-Signature:	

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Patient Label