ST. MARY'S HEALTH CARE SYSTEM
A Member of Trinity Health

OUTPATIENT ORDER FORM
OUTPATIENT SERVICES

Appt. Date/Time: _____

Arrival Time: _____

TO SCHEDULE: 706-389-2700 **FAX THIS ORDER** and required clinical records to: 706-389-2711

OUTPATIENT DIAGNOSTIC CENTER: 2470 Daniells Bridge Rd., Bldg. 300, Athens, GA | **MAIN HOSPITAL:** 1230 Baxter St., Athens, GA

PATIENT'S LEGAL NAME	DATE OF BIRTH	PATIENT PHONE	INSURANCE COMPANY NAME

PHYSICIAN OFFICES Tests cannot be performed without listing the signs/symptoms and/or reason(s) for each test ordered along with the ICD-10 code. Federal law requires that we inform you when ordering tests that will be paid under federal health programs, including Medicare and Medicaid, physicians should only order tests that are medically necessary for diagnosis or treatment of the patient, not for screening purposes.

Your office will be contacted prior to test being performed if form is not complete.

PATIENT SIGNS/SYMPTOMS	ICD-10 CODE:

PHYSICIAN NAME (please print)

❑ CALL REPORT TO_____

❑ FAX REPORT TO_____

X_____ _____

ORDERING PHYSICIAN'S SIGNATURE DATE/TIME

Signature Stamps Are Not Valid

SPECIAL INSTRUCTIONS

APPOINTMENTS NECESSARY FOR EXAMS LISTED BELOW

ENDOSCOPY/SPECIAL PROCEDURE

(Hospital Only)

____ Gastroscopy
____ Colonoscopy
____ Flex. Sigmoidoscopy
____ ERCP
____ Other_____
____ Esophageal Dilatation
____ Bronchoscopy
____ ph Probe

VASCULAR SERVICES

(Available at Hospital & Outpatient Diagnostic Center)

____ Venous Lower Ext. Bilat
____ Venous Lower Ext. R__ L__
____ Venous Upper Ext. Bilat
____ Venous Upper Ext. R__ L__
____ ABI - Limited Arterial Study
____ Aorta Scan/Doppler
____ Temporal Artery Doppler
____ Arterial Scan Lower Ext Bilat
____ Arterial Scan Lower Ext R___ L___
____ Arterial Scan Upper Ext Bilat
____ Arterial Scan Upper Ext R___ L___
____ Other _____
____ Arterial Doppler Lower (segmentals)
____ Arterial Doppler Lower w/ Exercise
____ Arterial Doppler Upper (segmentals)
____ Carotid Duplex Exam
____ Renal Artery Doppler

CARDIOLOGY SERVICES

____ EKG _____ Rhythm Strip
____ Exercise Stress Test
____ Nuclear Exercise Stress Test
____ Lexiscan Stress Test
____ Cardiac Event Monitor
____ Ambulatory BP Monitor
____ Holter Monitor (Specify 24 or 48 hours)
____ Longterm Holter (Specify 3-14 days)
____ Other _____
____ ECHOcardiogram
____ TEE
____ Stress Echo
____ Dobutamine Stress Echo
____ Oncology Echo
____ Echo with Contrast

RESPIRATORY SERVICES

(Hospital Only)

____ Arterial Blood Gas/Co-Ox
____ Oximeter Exercise Study
____ Other _____

Pulmonary Function Tests

____ DLCO*
____ Lung Volumes*
____ Pre/Post Bronchodilators*
____ Spirometry*
____ Complete ( )
____ Methacholine Challenge

NEURODIAGNOSTIC LAB

(Hospital Only)

____ EEG
____ Ambulatory EEG
____ NCV - Upper Extremity: R__ L__
____ NCV - Lower Extremity: R__ L__
____ EMG - Upper Extremity: R__ L__
____ EMG - Lower Extremity: R__ L__

NUTRITION SERVICES

(Hospital Only)

____ Medical Nutrition Therapy (Nutrition Assessment/Consultation)

Reason for Visit _____

_____

AMBULATORY INFUSION SUITE

To Schedule: 706-389-2365

____ Blood transfusions
____ Injections
____ Hydration/IV Infusion
____ Other _____
____Wound Care Suite
____ RhoGam

REHABILITATION SERVICES

(Outpatient Diagnostic, Rehab & Wellness Only)

To Schedule: Call 706-389-2950
Fax this order and required clinical records to:
706-389-2951

____ Physical Therapy _____
____ Occupational Therapy _____
____ Speech Therapy _____
____ Pelvic Health Physical Therapy _____