

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Name of Insurance Provider/ Group #/ ID #: \_\_\_\_\_

 Pre-Certification:  Not Required  In Progress  Completed Pre-Cert/ Authorization #: \_\_\_\_\_ Cash Pay: 

## 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

 Requested Test Date: \_\_\_\_\_  ROUTINE at patient's convenience  URGENT w/in 48 hours  STAT

If Contrast Study: Creatinine: \_\_\_\_\_ GFR: \_\_\_\_\_ Date: \_\_\_\_\_

<b>CT</b> <input type="checkbox"/> Oral Contrast <input type="checkbox"/> W/ IV Contrast <input type="checkbox"/> W/O IV Contrast <input type="checkbox"/> W/ and W/O IV Contrast <input type="checkbox"/> CTA	<input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Head/Brain <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Sinus <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Extremity (specify): _____ <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat. <input type="checkbox"/> Other (specify): _____
<b>MRI</b> <input type="checkbox"/> W/O Contrast <input type="checkbox"/> W/ Contrast	<input type="checkbox"/> Abdomen (specify): _____ <input type="checkbox"/> Kidneys <input type="checkbox"/> Liver <input type="checkbox"/> MRCP <input type="checkbox"/> Brain <input type="checkbox"/> Carotid <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Coccyx <input type="checkbox"/> IACs <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Sacrum <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Extremity (specify): _____ <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat. <input type="checkbox"/> Other (specify): _____
<b>ULTRASOUND</b>	<input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Abdomen Limited <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Pelvic Other (Specify): _____ <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Extremity: _____ <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Arterial Doppler <input type="checkbox"/> Extremity: _____ <input type="checkbox"/> L <input type="checkbox"/> R
<b>X-RAY</b>	<input type="checkbox"/> Other (specify): _____

## PHYSICIAN INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

Practitioner's Email: \_\_\_\_\_

Practitioner's Phone Number: \_\_\_\_\_ Practitioner's Fax Number: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice: Milwaukee ER & Hospital is unable to bill Medicare, Medicaid, and Tricare for services rendered.**