St. John's Hospital

AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

OUTPATIENT ORDER FORM

OUTPATIENT REGISTRATION–ENTER THROUGH THE MAIN ENTRANCE, AT 9TH AND CARPENTER STREET
HOURS: 5:30 A.M. – 7:00 P.M. MONDAY THROUGH FRIDAY–WEEKENDS AND HOLIDAYS ENTER THROUGH ED
PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT FOR REGISTRATION PROCESS

Pt. Name:_____

D.O.B._____ SS#:_____

Appointment Date: _____ Time:_____

Precertification #:_____

PHYSICIAN:Tests preceded by ● must be scheduled by your office. Call Centralized Scheduling 757–6565, unless otherwise indicated. Send form with patient or Fax to 757–6874.

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RADIOLOGY

ICD–9 – DX

- ☐ ANKLE ❑R ❑L _____
- ☐ CERVICAL SPINE _____
- ☐ CHEST _____
- ☐ ELBOW ❑R ❑L _____
- ☐ FINGER (specify) _____ _____
- ☐ FOOT ❑R ❑L _____
- ☐ HIP ❑R ❑L _____
- ☐ KNEE ❑R ❑L _____
- ☐ LUMBAR SPINE _____
- ●☐ MAMMOGRAMS – DX _____
- ☐ MAMMOGRAM – SCREENING _____
- ☐ PELVIS _____
- ☐ SHOULDER ❑R ❑L _____
- ☐ SKULL _____
- ☐ THORACIC SPINE _____
- ☐ TOMOGRAMS OF _____ _____
- ☐ WRIST ❑R ❑L _____
- ☐ OTHER_____ _____
- ☐ BONE DENSITY _____
- _____ _____

COMMENTS _____

_____

CONTRAST STUDIES

ICD–9 – DX

- ●☐ ARTHROGRAM OF _____
- ●☐ **COLON** _____
- ●☐ SPEECH ESOPHAGRAM/OROPHARYNGEAL SWALLOW STUDY _____
- ●☐ **GALLBLADDER** _____
- ●☐ **IVP** _____
- ●☐ **UPPER GI** _____
- ●☐ **UPPER GI, SMALL BOWEL** _____
- ●☐ VENOGRAM OF_____ _____
- ●☐ MYELOGRAM OF_____ _____
- ●☐ ARTERIO/ANGIOGRAM OF _____
- ●☐ OTHER _____ _____
- _____ _____

COMMENTS_____

_____

ULTRASOUND

ICD–9 – DX

- ●☐ **GALLBLADDER** _____
- ●☐ **UPPER ABDOMEN** _____
- ●☐ **PELVIC** _____
- ●☐ **OB** _____
- ●☐ BREAST _____
- ●☐ OTHER_____ _____
- _____ _____

COMMENTS_____

_____

CT SCANS

ICD–9 – DX

- ●☐ HEAD W/O CONTRAST _____
- ●☐ HEAD W & W/O CONTRAST _____
- ●☐ CHEST WITH CONTRAST _____
- ●☐ CHEST W/O CONTRAST _____
- ●☐ **ABD/PELVIS W & W/O CONT.**_____
- ●☐ **ABDOMEN W/O IV CONTRAST**_____
- ●☐ PELVIS (BONY DETAIL) W CONT. _____
- ●☐ PELVIS (BONY DETAIL) W/O CONT. _____
- ●☐ LUMBAR SPINE W/O CONTRAST _____
- ●☐ OTHER _____ _____
- _____ _____

COMMENTS_____

_____

MAGNETIC RESONANCE IMAGING

ICD– 9– DX

- ●☐ BRAIN _____
- ●☐ MRA _____
  - ☐ HEAD _____
  - ☐ NECK _____
  - ☐ OTHER _____
- ●☐ CHEST _____
- ●☐ ABDOMEN _____
- ●☐ SOFT TISSUE NECK _____
- ●☐ SPINE _____
  - ☐ CERVICAL _____
  - ☐ THORACIC _____
  - ☐ LUMBAR _____
- ●☐ ANKLE ❑R ❑L _____
- ●☐ ELBOW ❑R ❑L _____
- ●☐ FOOT ❑R ❑L _____
- ●☐ HIP ❑R ❑L _____
- ●☐ SHOULDER ❑R ❑L _____
- ●☐ WRIST ❑R ❑L _____
- ●☐ PELVIS ❑R ❑L _____
- ●☐ OTHER_____ _____
- _____ _____

COMMENTS_____

_____

NUCLEAR MEDICINE

ICD–9 – DX

- ●☐ **THYROID UPTAKE & SCAN** _____
- ●☐ V Q SCAN _____
- ●☐ MUGA _____
- ●☐ WHOLE BODY BONE SCAN _____
- ●☐ **HIDA** _____
- ●☐ **HIDA W CCK** _____
- ●☐ OTHER _____ _____
- _____ _____

COMMENTS _____

_____

END

ICD–9 – DX

- ●☐ **ROUTINE EEG** _____
- ●☐ **NASOPHARYNGEAL EEG** _____
- ●☐ **B A E R** _____
- ●☐ **VER** _____
- ●☐ **SSEP** _____
- ●☐ **UPPER EXTREMITY – SSEP** _____
- ●☐ **LOWER EXTREMITY – SSEP**_____
- ●☐ **MSLT** _____
- ●☐ **SLEEP STUDY** _____
- ●☐ **24 HOUR AMBULATORY EEG** _____
- ●☐ OTHER OR SPECIAL INSTRUCTIONS_____
- _____ _____
- _____ _____

COMMENTS_____

_____

REGISTRATION/SERVICES IN ST. JOHN'S HOSPITAL PAVILION

GASTROINTESTINAL DIAGNOSTIC AREA ICD–9 – DX

- ●☐ **EGD** _____
- ●☐ **ESOPHAGEAL DILATATION** _____
- ●☐ **COLONOSCOPY – DIAGNOSTIC** _____
- ●☐ **COLONOSCOPY – SCREENING/SURVEILLANCE** _____
- ●☐ **PROCTO SIGMOIDOSCOPY** _____
- ●☐ **ERCP** _____
- ●☐ **FLEXIBLE SIGMOIDOSCOPY** _____
- ●☐ GASTROSTOMY TUBE ACCESSORIES/CHANGES _____
- ●☐ OTHER _____ _____

COMMENTS_____

_____

When ordering tests for which Medicare reimbursement will be sought, physicians (or other authorized individuals) should order only those tests that are considered medically necessary for the diagnosis or treatment of a patient. Any physician who orders a test which may be determined to be medically unnecessary by the government may be subject to civil penalties as determined by that government agency. Appropriate ICD–9 diagnosis coding must be provided to document the necessity of testing required.

Dx/SymptomICD9–CM Code1_____**2**_____**3**_____**4**_____

Call Results ☐ **YES** ☐ **NO** **Date:** _____**Time:**_____ _____ **M.D.**

Signature of Physician

A1194
Rev. 12/2010

OEYPHYORD

St. John's Hospital
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REHABILITATION: ICD–9 – DX

PHYSICAL THERAPY

- ● ❑ EVALUATION AND TREATMENT _____
- ● ❑ AQUATIC THERAPY _____
- ● ❑ CASTING _____

OCCUPATIONAL THERAPY ICD–9 – DX

- ● ❑ EVALUATION AND TREATMENT _____
- ● ❑ SPLINT FABRICATION _____
- ● ❑ CASTING _____

SPEECH THERAPY ICD–9 – DX

- ● ❑ EVAL AND TREATMENT _____
- ● ❑ SWALLOWING EVAL AND TREATMENT _____
- ● ❑ SPEECH ESOPHAGRAM/ OROPHARYNGEAL SWALLOW STUDY _____
- ● ❑ VOICE EVAL AND TREATMENT _____
- ● ❑ OTHER _____

COMMENTS_____

RENAL DIALYSIS EXT. 45740 ICD–9 – DX

- ● ❑ HOME DIALYSIS _____
- ● ❑ PERITONEAL DIALYSIS _____
- ● ❑ ULTRAFILTRATION _____
- ● ❑ OTHER _____ _____

COMMENTS_____

CARDIOVASCULAR ICD–9 – DX

- ❑ EKG _____
- ● ❑ ECHOCARDIOGRAM _____
- ● ❑ LOOPING EVENT MONITOR _____
- ● ❑ NON–LOOPING EVENT MONITOR _____
- ● ❑ HOLTER MONITOR _____
- ● ❑ **CARDIAC STRESS TEST** SPECIFY TYPE:_____
- ● ❑ CAROTID ULTRASOUND _____
- ● ❑ VENOUS DOPPLERS SPECIFY EXTREMITY: _____
- ● ❑ ANKLE/BRACHIAL INDEX _____
- ● ❑ BIO–Z _____
- ● ❑ OTHER _____ _____

COMMENTS_____

REGISTRATION/SERVICES PAVILION

WOUND, OSTOMY, CONTINENCE ICD–9–DX

- ● ❑ STOMA NURSE TO EVALUATE AND TREAT PRN _____
- ● ❑ OSTOMY APPLIANCES AND/OR ACCESSORIES PRN _____
- ● ❑ WOUND CARE NURSE TO EVALUATE AND TREAT PRN _____
- ● ❑ CONTINENCE NURSE TO EVALUATE AND TREAT PRN _____
  - ❑ BIOFEEDBACK _____
  - ❑ ELECTRICAL STIMULATION _____
  - ❑ URODYNAMICS _____
  - ❑ UROFLOWMETRY _____
- ● ❑ OTHER _____ _____

COMMENTS_____

BIRTH CENTER EXT. 30300 ICD–9 – DX

- ● ❑ NST _____
- ● ❑ OCT _____
- ● ❑ **OB ULTRASOUND** _____
- ● ❑ BIOPHYSICAL PROFILE _____
- ● ❑ LACTATION CONSULTATION _____
- ● ❑ OTHER _____ _____

COMMENTS_____

RESPIRATORY THERAPY ICD–9 – DX

- ● ❑ NEBULIZER THERAPY MEDICATION _____ _____
- ● ❑ CHEST PERCUSSION THERAPY / POSTURAL DRAINAGE AREAS _____ _____
- ● ❑ PULMONARY FUNCTION TEST (PFT) PULMONARY FUNCTION TEST WITH METHACHOLINE _____ _____
- ● ❑ PULMONARY REHABILITATION FOR DIAGNOSIS OF _____ _____
- ● ❑ **CARDIOPULMONARY STRESS TEST** _____
- ● ❑ INDIRECT CALORIMETRY TEST SPECIFY _____ _____
- ● ❑ HOME ARRANGEMENTS SPECIFY _____ _____
- ● ❑ OTHER _____ _____

COMMENTS_____

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Dx/SymptomICD9–CM Code1_____**2**_____**3**_____**4**_____

Call Results ☐ **YES** ☐ **NO** **Date:** _____**Time:**_____ _____ M.D.

Signature of Physician

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