



01899901

Outpatient Order Form

Required for exam to be completed
(Lab Work to be Ordered on Form # 01800001)



Appointment Date: _____

Appointment Time: _____ AM/PM Arrival Time: _____ AM/PM

PATIENT INFORMATION		ORDER DATE (REQUIRED)	
NAME		DATE OF BIRTH	
DIAGNOSIS (required)			
DIAGNOSIS CODE (ICD9 required)			
PHYSICIAN (required)		ORDERING PERSON (required)	
PHYSICIAN TO READ OR PERFORM		Circle One MD NP PA	
ADDITIONAL INFORMATION			
Copy to Dr. _____		Call to Dr. _____	Fax to # _____
<input type="checkbox"/> Patient needs creatinine: result _____		ALLERGIES _____	<input type="checkbox"/> Take Films

PLEASE PARK IN THE DESIGNATED PARKING LOTS AND REPORT TO THE REGISTRATION AREA LISTED ABOVE THE EXAM

PARKING - ORANGE LOT OUTPATIENT REGISTRATION-7A-9P (1840 AMHERST ST) CARDIOVASCULAR LAB (540) 536-8940 <input type="checkbox"/> Echocardiogram 2D <input type="checkbox"/> Dobutamine Echo <input type="checkbox"/> Stress Echo <input type="checkbox"/> TEE <input type="checkbox"/> Stress Test (Treadmill Only) <input type="checkbox"/> EKG (Can be done at Outpat. Lab) <input type="checkbox"/> 24 hr Holter Monitor <input type="checkbox"/> CVE (Carotid Ultrasound) <input type="checkbox"/> Pulse Volume Recording (PVR-legs) INVASIVE CARDIOLOGY/CATH LAB (540) 536-8686 <input type="checkbox"/> Cardioversion <input type="checkbox"/> Pacemaker <input type="checkbox"/> Tilt table <input type="checkbox"/> Heart Catheterization <input type="checkbox"/> Left <input type="checkbox"/> Right NEURODIAGNOSTIC/SLEEP LAB (540) 536-8165 <input type="checkbox"/> EEG (Electroencephalogram) <input type="checkbox"/> 24 hour Ambulatory EEG <input type="checkbox"/> Tilt Table (Neuro) <input type="checkbox"/> VEP <input type="checkbox"/> BAEP <input type="checkbox"/> SEP Median <input type="checkbox"/> SEP TIBAL <input type="checkbox"/> NCV <input type="checkbox"/> EMG SLEEP LAB (540) 536-8165 <input type="checkbox"/> Polysomnogram (All night sleep study) <input type="checkbox"/> MSLT (mult sleep latency test) RADIOLOGY (540) 536-8750 <input type="checkbox"/> Arthrogram <input type="checkbox"/> Cookie Swallow <input type="checkbox"/> Cystourethrogram <input type="checkbox"/> Discogram <input type="checkbox"/> Facet/Nerve Root Block <input type="checkbox"/> SI Joint <input type="checkbox"/> IVP <input type="checkbox"/> IVP w/Tomograms <input type="checkbox"/> Myelogram <input type="checkbox"/> Nephrostogram/Loopogram <input type="checkbox"/> T-Tube Cholangiogram <input type="checkbox"/> Tubogram./HSG <input type="checkbox"/> Venogram - Leg <input type="checkbox"/> Voiding Cystourethrogram (VCUG) CT/US emergencies/after 5 p.m. <input type="checkbox"/> CT: Specify _____ <input type="checkbox"/> US: Specify _____ SPECIAL PROCEDURES (540) 536-8752 <input type="checkbox"/> Angiogram/Arteriogram <input type="checkbox"/> AV Shunt (Fistulagram) <input type="checkbox"/> Venogram - Arm EPO CLINIC <input type="checkbox"/> (540) 536-8778	PARKING - ORANGE LOT IMAGING CTR. REGISTRATION-6A-10P (M-F) CT SCAN (540) 536-8851 <input type="checkbox"/> W/contrast <input type="checkbox"/> W/O contrast <input type="checkbox"/> Abdomen <input type="checkbox"/> Chest <input type="checkbox"/> Head <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Limited <input type="checkbox"/> Neck (Soft tissue) <input type="checkbox"/> Pelvis <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Other <input type="checkbox"/> MRI <input type="checkbox"/> MRA <input type="checkbox"/> W/contrast <input type="checkbox"/> W/O contrast <input type="checkbox"/> Abdomen <input type="checkbox"/> Brain <input type="checkbox"/> Carotid Neck <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic <input type="checkbox"/> Joint <input type="checkbox"/> Left <input type="checkbox"/> Right SPECIFY: _____ NUCLEAR MEDICINE (540) 536-8797 <input type="checkbox"/> Bleeding Scan BONE SCAN <input type="checkbox"/> Multi Area <input type="checkbox"/> SPECT <input type="checkbox"/> 3 Phase <input type="checkbox"/> Whole Body <input type="checkbox"/> Cardiolite Scan - 2 Day CARDIOLITE STRESS TEST <input type="checkbox"/> Adenosine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Exercise <input type="checkbox"/> Ceretec WBC Imaging <input type="checkbox"/> Ceretec Brain <input type="checkbox"/> Gallbladder HIDA <input type="checkbox"/> W/ Eject Fract <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Indium WBC Imaging <input type="checkbox"/> Liver SPECT Hemangioma <input type="checkbox"/> Liver Scan <input type="checkbox"/> Lung (V/Q) <input type="checkbox"/> Meckel's Scan <input type="checkbox"/> MUGA <input type="checkbox"/> Parathyroid <input type="checkbox"/> Radionuclide VCUG <input type="checkbox"/> Renal Scan <input type="checkbox"/> GFR <input type="checkbox"/> W/Lasix <input type="checkbox"/> Renal Scan <input type="checkbox"/> W/ Captopril <input type="checkbox"/> Resting Thallium Scan <input type="checkbox"/> Scintomammogram <input type="checkbox"/> Thallium Myocardial Viability Thyroid <input type="checkbox"/> Scan Only <input type="checkbox"/> Uptake Only <input type="checkbox"/> Uptake & Scan <input type="checkbox"/> Thyroid Therapy Consultation <input type="checkbox"/> Bone Pain Therapy Consultation PET Imaging (536-6495 to schedule) RESPIRATORY SERVICES (540) 536-8940 <input type="checkbox"/> Arterial Blood Gases <input type="checkbox"/> Pulse Oximetry <input type="checkbox"/> Sputum Collection <input type="checkbox"/> Other Pulmonary Function Test <input type="checkbox"/> PFT/Regular <input type="checkbox"/> Methacholine Challenge	PARKING - PURPLE LOT ENDOSCOPY CENTER REGISTRATION 6:30A-5P (540) 536-8746 190 CAMPUS BLVD-MOB 2 SUITE 100 <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Colon <input type="checkbox"/> Sigmoid <input type="checkbox"/> Esophageal/Gastric <input type="checkbox"/> Liver Biopsy <input type="checkbox"/> Minor Surgery <input type="checkbox"/> Transfusion/Infusion/Phlebotomy SPECIFY: _____ PARKING-BLUE LOT OR ORANGE LOT DIAGNOSTIC CTR. REGISTRATION (OPDC) MOB 1 7:30 a-4:30p (540) 536-8927 <input type="checkbox"/> Barium Enema <input type="checkbox"/> Single contrast <input type="checkbox"/> Barium Swallow/Esophogram <input type="checkbox"/> Dextra Scan/Bone Density Study <input type="checkbox"/> Gall Bladder x-ray/Oral Cholecystogram <input type="checkbox"/> Mammogram (use detailed MAMMO form) <input type="checkbox"/> Small Bowel Only <input type="checkbox"/> Upper G.I. Series <input type="checkbox"/> Upper G.I. with Small Bowel <input type="checkbox"/> Ultrasound <input type="checkbox"/> Abdomen <input type="checkbox"/> Breast <input type="checkbox"/> Extremity _____ <input type="checkbox"/> Head/Neck (soft tissue) <input type="checkbox"/> Leg (DVT) - Venous study <input type="checkbox"/> Pelvic <input type="checkbox"/> Pregnant Uterus <input type="checkbox"/> Transvaginal <input type="checkbox"/> Retroperitoneal <input type="checkbox"/> Testicular/scrotal PARKING-BROWN LOT HURST HOUSE/WRC REGISTRATION (540) 536-8095 <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy PARKING-APPLE BLOSSOM MALL NUTRITION CLINIC REGISTRATION <input type="checkbox"/> Apple Blossom Mall - Health Depot Number of visits _____ (540) 536-4165
PATIENT LABEL		