RED RIVER ER & HOSPITAL

REQUEST FOR OUTPATIENT SERVICES

2022 N Hwy 75, Sherman, TX 75090
Phone: 430-362-8034 • Fax: 430-208-2246

PATIENT INFORMATION

Last Name: ____________ **First Name:** ____________ **Middle Name:** ____________

Date of Birth: ____________ **Primary Phone Number:** ____________

Name of Insurance Provider/ Policy #: ____________

Pre-Certification: ☐ **Not Required** ☐ **In Progress** ☐ **Completed** **Pre-Cert/ Authorization#** ____________

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 *Orders are valid for 90 days.

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

X-RAY	☐ Other (specify): ____________			
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain	☐ Neck (Soft Tissues)	☐ Pelvis	☐ Chest
	☐ Sinus	☐ Cervical Spine	☐ Chest	☐ Abdomen
	☐ Lumbar Spine	☐ Thoracic Spine	☐ L ☐ R	☐ Bilat.
	☐ Extremity (specify): ____________		☐ Upper	☐ Lower
	☐ Other (specify): ____________		Creatinine:______ GFR:______	Date:______
MRI ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Carotid MRA	☐ Brain MRI	☐ Pelvis	☐ Coccyx
	☐ Brain MRA	☐ Neck (Soft Tissues)	☐ Sacrum	☐ IACs
	☐ Lumbar Spine	☐ Cervical Spine	☐ Foot L/R	☐ Wrist L/R
	☐ Thoracic Spine	☐ Shoulder L/R	☐ Hand L/R	☐ Knee L/R
	☐ Orbits	☐ Elbow L/R	☐ Hip L/R	☐ Ankle L/R
	☐ If Claustrophobic	☐ Upper Arm Non-Joint L/R	☐ Lower Arm Non-Joint L/R	
		☐ Upper Leg Non-Joint L/R	☐ Lower Leg Non-Joint L/R	
	☐ Other (specify): ____________		Creatinine:______ GFR:______	Date:______
	☐ Abdomen (specify):	☐ Liver	☐ Kidneys	☐ MRCP

PHYSICIAN INFORMATION

Referring Practitioner: **Last Name:** ____________ **First Name:** ____________ **NPI#:** ____________

Practitioner's Phone Number: ____________ **Practitioner's Fax Number:** ____________

Practitioner's Signature: ____________ **Date:** ____________

Notice: Red River ER & Hospital is unable to bill Medicare, Medicaid for services rendered.

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