



PROVIDENCE
HOSPITAL

1150 Varnum Street, N.E.
Washington, DC 20017

OUTPATIENT DIAGNOSTIC SERVICES REQUEST FORM

TO BE COMPLETED BY HOSPITAL

Encounter#		MR#	Patient Name (Last, First Middle)	
Social Security#		Date of Test	Street Address	Date of Birth
			City	State Zip

SHADED AREAS TO BE COMPLETED BY REFERRING PHYSICIAN

Diagnoses/Reason for Procedure:

1. Physician Signature	2. Print Physician Name	3. Date	4. <input type="checkbox"/> Preadmission Testing <input type="checkbox"/> Outpatient Testing (Must Schedule With Each Department)
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This will introduce (Patient Name) who is being referred for the following procedures:

Special Instructions / Orders:

TESTS MARKED WITH ASTERICK (*) REQUIRE ADVANCE APPOINTMENT

DIAGNOSTIC RADIOLOGY Hours of Service M-F 8:00 A.M. - 4:30 P.M. Sat Only 8:30 A.M. - 12:00 Noon Appointments may be made from 8:30 A.M. to 4:30 P.M. M-F, at these numbers: Mammography 269-7958 All other studies 269-7055	CHEST <input type="checkbox"/> Chest, Pa. & Lat. <input type="checkbox"/> Rib(s) ABDOMEN <input type="checkbox"/> AP (KUB) <input type="checkbox"/> Abd. Multi. Views HEAD <input type="checkbox"/> Mandible <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Skull <input type="checkbox"/> C.T. SCAN* (Specify body part) EXAM(S) _____ EXAM(S) _____	SPINE AND PELVIS <input type="checkbox"/> C. Spine <input type="checkbox"/> T. Spine <input type="checkbox"/> L-S Spine <input type="checkbox"/> Pelvis, AP UPPER EXTREMITIES <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus (arm) <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrists <input type="checkbox"/> Hand M.R.I. * _____ (Specify body part)	LOWER EXTREMITIES <input type="checkbox"/> Hip(s) <input type="checkbox"/> Femur (thigh) <input type="checkbox"/> Knee <input type="checkbox"/> Tibia & Fibula (leg) <input type="checkbox"/> Ankle <input type="checkbox"/> Foot GASTROINTESTINAL * <input type="checkbox"/> Esophagus* <input type="checkbox"/> UGI* <input type="checkbox"/> Small Bowel* <input type="checkbox"/> B.E. w Air* <input type="checkbox"/> B.E.* <input type="checkbox"/> G.B. <input type="checkbox"/> Swallowing Function* GENITOURINARY * <input type="checkbox"/> _____ APPT. DATE _____ TIME _____ APPT. DATE _____ TIME _____	MAMMOGRAPHY * <input type="checkbox"/> Unilateral (tailored)* <input type="checkbox"/> Bilateral (tailored)* <input type="checkbox"/> Screening* ARTHROGRAPHY <input type="checkbox"/> _____ (Specify joint) ULTRASOUND * <input type="checkbox"/> Abdominal* <input type="checkbox"/> Pelvic (O.B.)* <input type="checkbox"/> Pelvic (Non O.B.)* OTHER _____
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DIAGNOSTIC CLINICAL LABORATORY Phone: 269-7917 Hours of Service M-F 8:00 AM - 5:00 PM Sat. Only 8:00 A.M. - 12:00 Noon	<input type="checkbox"/> CBC <input type="checkbox"/> Routine Urinalysis <input type="checkbox"/> Prottime <input type="checkbox"/> PTT <input type="checkbox"/> Liver Profile	<input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Electrolytes <input type="checkbox"/> Glucose <input type="checkbox"/> Type & Rh	<input type="checkbox"/> Lipid Profile (Chol Trig, HDLC) <input type="checkbox"/> Glucose Tolerance* <input type="checkbox"/> Additional tests on separate lab request form.
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DIAGNOSTIC CARDIOLOGY Phone: 269-7118	<input type="checkbox"/> ECG <input type="checkbox"/> EEG*	<input type="checkbox"/> 24 hr Holter monitoring* <input type="checkbox"/> ECHO	<input type="checkbox"/> Other
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APPOINTMENT REQUIRED FOR ALL SERVICES BELOW

NUCLEAR MEDICINE Phone 269-7180	<input type="checkbox"/> Bone Imaging <input type="checkbox"/> Total Body <input type="checkbox"/> SPECT: Area <input type="checkbox"/> 3-Phase: Area <input type="checkbox"/> Gallium Imaging	<input type="checkbox"/> Liver-Spleen Imaging <input type="checkbox"/> SPECT Liver-Spleen <input type="checkbox"/> Hemangioma-Liver <input type="checkbox"/> Hepatobiliary Imaging (HIDA) <input type="checkbox"/> G1 Bleeding Study	Cardiac Studies <input type="checkbox"/> Thallium 201 <input type="checkbox"/> Stress <input type="checkbox"/> Rest <input type="checkbox"/> Wall Motion (MUGA) <input type="checkbox"/> Stress <input type="checkbox"/> Rest	<input type="checkbox"/> Thyroid Imaging & Untake <input type="checkbox"/> Renogram (Kidney Imaging) <input type="checkbox"/> Lung Imaging <input type="checkbox"/> Indium-WBC Imaging <input type="checkbox"/> Other
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REHABILITATIVE SERVICES Phone 269-7657	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech and Language Therapy <input type="checkbox"/> Other
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VASCULAR STUDIES Phone 269-7118	<input type="checkbox"/> Lower Extremity Arterial <input type="checkbox"/> Venous Flow Patterns	<input type="checkbox"/> Carotid Duplex Scan <input type="checkbox"/> Upper Extremity Arterial	<input type="checkbox"/> Quant. Venous Flow Studies <input type="checkbox"/> Venous 3-Scan Img. Lower Ex.	<input type="checkbox"/> Impedance Study <input type="checkbox"/> OPG Study
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RESPIRATORY CARE SERVICES PULMONARY FUNCTIONS Phone 269-7119	<input type="checkbox"/> Spirometry Baseline <input type="checkbox"/> Spirometry a&p Bronchodilator <input type="checkbox"/> ABG <input type="checkbox"/> Breath Alcohol Testing	<input type="checkbox"/> Full Lung Volumes <input type="checkbox"/> Diffusion Capacity <input type="checkbox"/> Pox Spot	OTHER <input type="checkbox"/> _____ <input type="checkbox"/> _____
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OBSTETRICS Phone: 269-7678 Phone: 269-7364	<input type="checkbox"/> Non-Stress Test <input type="checkbox"/> Oxylocin Challenge Test	Phone: 269-7364 Phone: 269-7752	<input type="checkbox"/> BSST <input type="checkbox"/> Biophysical Profile
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NUTRITION SERVICES Phone 269-7842	<input type="checkbox"/> Diet Instructions (first visit) Diet Prescription: <input type="checkbox"/> Diet Instructions (follow up) Diet Prescription:	<input type="checkbox"/> Comp. Nut Analysis <input type="checkbox"/> Other
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