CCOM MEDICAL GROUP – DIAGNOSTIC TESTING CENTER

350 South 40th Street, Muskogee, OK 74401-4915
Phone (918) 683-0456 Fax (918) 913-3113

DIAGNOSTIC TEST ORDER

PATIENT NAME: _____ DATE OF BIRTH: _____

URGENCY OF TEST (circle one): Stat Urgent Routine

DIAGNOSIS: _____ ICD-10 CODE: _____ HT: _____ WT: _____

SECONDARY DIAGNOSIS: _____ ICD-10 CODE: _____

Order	CPT	Nuclear Imaging Procedures		Order	CPT	Other Test Procedures
	78452	PTE – Persantine/Lexi/TE			93000	EKG
	78452	Thallium Viability			93015	Treadmill Stress Test (non-nuclear)
	78472	MUGA			93224	Holter Monitor
					93268	Event Recorder
	78304	Bone Scan / Whole Body				
	78315	Bone Scan / Three Phrase			93922	Arterial Study Unilateral
					93924	Arterial Study Bilateral
	78014	Thyroid Uptake / Scan				
	79005	Thyroid Therapy			94060	Pulmonary Function Study (spirometery only)
	78018	Thyroid I-123 Whole Body Bone Scan				
	78071	Parathyroid Imaging			93965	Venous Mapping
					93970	Venous Study Comp Bilateral
	78227	HIDA Scan			93971	Venous Doppler Unilateral
	78226	Heptabiliary				
	78264	Gastric Emptying			93306	Echo
	78290	Meckels Diverticula			77085	Bone Density
	78258	Esophageal Transmit			93880	Carotid Duplex Bilateral
	78230	Salivagram			76536	Thyroid Ultrasound
					76881	Soft Tissue Ultrasound
	78708	Diuretic Renal Scan			76770	Kidney
	78707	GFR / DMSA / Mass Renal Scan			76705	Abdomen
	78709	Captopril Study			76870	Testicles
	78195	Lymphoscintigraphy			93978	Aorta
	78582	VQ Lung Scan				

Additional Information / Remarks: _____

_____

_____

ORDERING PHYSICIAN SIGNATURE: _____ DATE: _____

CCOM MEDICAL GROUP – DIAGNOSTIC TESTING CENTER

350 South 40th Street, Muskogee, OK 74401-4915
Phone (918) 683-0456 Fax (918) 913-3113

(Diagnostic Testing Request Form must be attached to this order for proper processing and scheduling.)

DIAGNOSTIC TESTING REQUEST FORM

REQUESTING PHYSICIAN: _____ PHONE: _____

BEST NUMBER TO SEND OR CALL RESULTS TO: FAX_____ PHONE_____

URGENCY OF TEST (circle one): Stat Urgent Routine

PATIENT DEMOGRAPHICS

NAME: _____ HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____

INSURANCE INFORMATION – PRIMARY INSURANCE

INSURED NAME: _____ POLICY NUMBER: _____

INSURED SSN: _____ INSURED DATE OF BIRTH: _____

INSURANCE CARRIER: _____ PHONE: _____

INSURANCE INFORMATION – SECONDARY / SUPPLEMENTAL INSURANCE

INSURED NAME: _____ POLICY NUMBER: _____

INSURED SSN: _____ INSURED DATE OF BIRTH: _____

INSURANCE CARRIER: _____ PHONE: _____

Please attach a copy of:

1. Insurance ID cards.
2. Current medication list.
3. Current lab results, if applicable.
4. Copy of recent medical reports, i.e. cardiac procedures, EKG, ECHO, Ultrasound, CT, MRI, etc., if applicable.
5. Copy of insurance carrier authorization or referral, if applicable.

CCOM MEDICAL GROUP – DIAGNOSTIC TESTING CENTER

350 South 40th Street, Muskogee, OK 74401-4915
Phone (918) 683-0456 Fax (918) 913-3113

Note: If all information is not received at least 2 days prior to the scheduled procedure/test we may need to contact you to reschedule the patient for a later date. Please do not hesitate to call us if you have any questions. Thank you for the opportunity to participate in the healthcare of your patient.