HSHS
St. Anthony's
Memorial Hospital

DIAGNOSTIC SERVICES ORDERS

Pre-Authorization #: ______________________ Name: ______________________

Diagnosis / Indications: ◆ (Required for billing / reimbursement) Date of Birth: ________ ❑ OP1X ❑ OP-R

1. ______________________
2. ______________________
3. ______________________

Any test for screening? ❑ Yes ❑ No

PLACE LABEL HERE

Please list: ______________________

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Type of Order: ❑ STAT ❑ Routine

Reports by: ❑ Mailbox ❑ Fax (#) ________

❑ Patient to wait for phone/fax results ❑ Phone Rept (#) ________

DIAGNOSTICS SERVICES ORDER

	CARDIOLOGY		NEUROLOGY		VASCULAR
	EKG		POLYSOMNOGRAPHY W/CPAP		ARTERIAL DOPPLER UPPER
	HOLTER MONITOR		POLYSOMNOGRAPHY W/O CPAP		VENOUS REFLUX
	❑ 24 hour ❑ 48 hour ❑ ______		LIMITED W/CPAP		UPPER BIL VENOUS
	EVENT MONITOR		LIMITED W/O CPAP		LOWER BIL VENOUS
	AMBULATORY BP MONITOR		EEG		UPPER UNILATERAL VENOUS
	ECHO		1.0.M EEG		LOWER UNILATERAL VENOUS
	CARDIAC 2D/COLOR/DOPPLER ECHO – ROUTINE		EMG		AORTA ILIAC ARTERY DUPLEX
	CARDIAC 2D/COLOR/DOPPLER ECHO – LIMITED		❑ UPPER ❑ LOWER		ANKLE BRACHIAL INDEX (ABI)
	CONGENITAL ECHO – PEDIATRIC		1 EXTREMITY		EXERCISE ARTERIAL STUDY
	LMITED CONGENITAL ECHO – PEDIATRIC		2 EXTREMITY		CAROTID DUPLEX
	TRANSESOPHAGEAL ECHO		3 EXTREMITY		UNILATERAL
	STRESS TEST		4 EXTREMITY		BILATERAL
	STRESS ECHO		1.0.M. SSEP		VENOUS DUPLEX
	DOBUTAMINE STRESS ECHO		PULMONARY FUNCTION TEST		ARTERIAL DUPLEX
*Contrast per protocol if needed			W/BRONCHO DILATOR ❑ ALBUTEROL 2.5MG NEBULIZED ONCE		❑ UPPER ❑ LOWER
	ROUTINE TREADMILL STRESS TEST		W/O BRONCHO DILATOR		ARTERIAL GRAFT EVAL
	NUCLEAR TREADMILL STRESS W/CARDIOLITE		DLCO		UNILATERAL
	PHARMCOLOGICAL CARDIOLITE STRESS WITH ❑ REGADENOSON ❑ ADENOSINE		FVC POST		BILATERAL
			MVV		RENAL DUPLEX
	PHARMCOLOGICAL CARDIOLITE STRESS AND LOW LEVEL WALK WITH/ ❑ REGADENOSON ❑ ADENOSINE		BODY BOX FRC		AAA SCREEN
			SLOW VITAL CAPACITY		H.D. ACCESS GRAFT EVAL
			FVC PRE		DUPLEX SCAN PSEUDO CHECK
			PFT SCREEN		
			SPIROMETRY METHACHOLINE CHALLENGE TEST		OTHER
			ALBUTEROL ADMINISTRATION WITH PFT		HEARING SCREEN
					TYMPANOGRAM

SCHEDULED DATE & TIME:	INSTRUCTIONS:

DATE __________ TIME __________ **ORDERING PHYSICIAN SIGNATURE*** ______________________

Additional copies to: ______________________

***SIGNATURE STAMP UNACCEPTABLE AUTHENTICATION. PLEASE SIGN.**

REGISTRATION FAX #: 347-1377

C8711_132 PS#10072867
Rev. 12/19/2019
12-27-2019 3:16:46 PM

JZ

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