



Arkansas Children's Hospital
Referred Patient Requisition / Order / Referral
Ancillary Services

NOTE: ORDERS WILL NOT BE PROCESSED WITHOUT THE APPROPRIATE INFORMATION COMPLETED AND THE PHYSICIAN'S SIGNATURE AFFIXED.

Patient Name:	Insurance Company:
Patient Address:	Insurance Policy Number:
Patient's Birthdate:	Insurance Referral #:
Phone #:	Medicaid Policy Number:
Mother's First Name:	Pre Authorization#:
ACH Medical Record #:	Medicaid Referral#: (NPI)
Referring / Ordering MD:	Pre Authorization Time Frame
Street:	Requested Date of Service _____
City:	
State:	
Zip:	

WRITE THE TEST / PROCEDURE / SUPPLY, LOCATION, AND THE APPROPRIATE DIAGNOSIS CODE IN THE SPACES BELOW.

All orders for tests /procedures /supplies must include the diagnosis /medical reason for the test. This must be an ICD 10 Diagnosis Code. All orders for supplies must also include the quantity.

Procedure / Supply	Location / Department	Please indicate the specific diagnosis code requiring the ordered test/procedure/supply. Do not use "rule out" diagnoses and avoid using "V" codes	
		ICD-10 Diagnosis	Diagnosis
Example: Sweat Test	Pulmonary Lab	J45.909	Asthma Unspecified
1.			
2.			
3.			
4.			
5.			
6.			

- ☐ Audiology Evaluation & Management
- ☐ Speech/Language/Feeding Evaluation & Management

ORDERING PHYSICIAN/APN Printed _____			
<input type="checkbox"/> Pregnancy Test if required for imaging study/procedure			
Duration of Order _____ Frequency of test/supply _____			
Source Document Name: _____		Date of Document _____	
Transcribed for _____		by _____ Title _____ Date _____ Time _____	
Physician / APRN Signature: _____		Printed Name: _____ Date: _____ Time: _____	
The above signed Physician / APN certifies that the ordered tests/ procedures are medically necessary for the diagnosis and treatment of the patient. I am responsible for the care of the patient.			
Contact Person:	Fax Results #:	Phone Results#:	

Please fax this form directly to the specified service:

ACH Outpatient Testing	(501) 364-3578	EEG	(501) 364-5440	Pulmonary Lab	501) 364-1887
Apheresis	(501) 364-2283	GI Lab	(501) 364-4658	Radiology	(501) 364-3549
Audiology / Speech	(501) 978-6440	Heart Station	501) 364-5440	Sleep Lab	(501) 364-6878
Burn Treatment	(501) 364-6480	Outpt Lab	(501) 364-3578	Supplies	(501) 364-3578
CFC - Lowell	(479) 750-0323				
Day Med	(501) 364-3804				

December 15, 2015



REF . PT . REQ . ANC