



**Centers for Children
Referred Patient Requisition Order / Referral
Ancillary Services**

Phone: 479-750-0125

Fax: 479-750-0323

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

Patient Name: Patient's Birthdate: Phone #: Mother's First Name: ACH Medical Record #: Referring / Ordering MD: Primary Care Physician: Requested Date of Service: _____	Insurance Policy Number: Insurance Referral # : Medicaid Policy Number Medicaid Referral # : (NPI) Referral Dates From _____ to _____
---	---

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 ICD9 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-9 Diagnosis (5-digit code)	Diagnosis
Example: Sweat Test	Pulmonary Lab	493.90	Asthma NOS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Source Document Name: _____ Date of Document) _____
 Scribed/Transcribed for _____ by _____ Title _____ Date _____ Time _____
 ORDERING PHYSICIAN/APN Printed _____

Duration of Order _____ Frequency of test/supply _____

For MRI's - General Anesthesia Sedation Team Sedation Team Radiology Sedation Area of Body: _____
 MRI Response: Date of Service: _____ Arrive at _____ No solids after _____ Clear liquids until _____

Physician / APN Signature: _____ Date: _____ Time: _____
 The above signed Physician / APN certifies that the ordered tests/ procedures are medically necessary for the diagnosis and treatment of the patient

Contact Person: _____ **Fax Results #:** _____ **Phone Results#:** _____

Please fax this form directly to the specified service:

- ACH Outpatient Testing (501) 364-3578
- Apheresis (501) 364-2283
- Burn Treatment (501) 364-6480
- CFC - Lowell (479) 750-0323
- Day Med (501) 364-3804

- EEG (501) 364-6281
- GI Lab (501) 364-4658
- Heart Station (501) 364-1422
- Outpt Lab (501) 364-3578
- PT / OT (501) 364-3564

- Pulmonary Lab (501) 364-1887
- Radiology (501) 364-3549
- Sleep Lab (501) 364-6878
- Supplies (501) 364-3578



REF. PT. REQ. ANC

October 24, 2011

