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

<table>
<thead>
<tr>
<th>Procedure / Supply</th>
<th>Location / Department</th>
<th>ICD-10 Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Sweat Test</td>
<td>Pulmonary Lab</td>
<td>J45.909 Asthma Unspecified</td>
</tr>
</tbody>
</table>

1.  
2.  
3.  
4.  
5.  
6.  

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

☐ Patient will be seen in ACH clinic/or ASC same day as radiology testing

ORDERING PHYSICIAN/APN Printed  
☐ 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 to: 501−978−6440

For ACH Pulmonary Lab: 501−364−1887