



CCOM MEDICAL GROUP – DIAGNOSTIC TESTING CENTER

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

DIAGNOSTIC TEST REQUISITION

PATIENT NAME: _____ DATE OF BIRTH: _____

URGENCY OF TEST (circle one): TODAY TOMORROW THIS WEEK NEXT WEEK

DIAGNOSIS: _____ ICD9 CODE: _____ HT: _____ WT: _____

SECONDARY DIAGNOSIS: _____ ICD9 CODE: _____

Order	CPT	Nuclear Imaging Procedures	Order	CPT	Other Testing Procedures
		PTE – Persantine		93000	EKG
		Adenoscan		93230	Holter Monitor
		Lexiscan		93268	Event Recorder
		MUGA		93015	Stress Test
		TE		93307	Echo
		Thyroid Uptake / Scan		93350	Dobutamine Echo
		Parathyroid Imaging		93350	Stress Echo
		Diuretic Renal Scan		93040	Rhythm Strip
		GFR / DMSA Renal Scan		93922	Arterial Study Bilateral
		Liver-Spleen Scan		93965	Venous Study Comp Bilateral
		HIDA Scan		93880	Carotid Duplex Bilateral
		Meckels Diverticula			
		Cystogram		94010	Pulmonary Function Study (spirometry only)
		Gastric Emptying			
		GI Bleed Scan		77080	Bone Density Axial Skeletal
		Captopril Study		77081	Bone Density App Skeletal
		Lymphoscintigraphy			
		Bone Scan / Whole Body		76536	Thyroid Ultrasound
		Bone Scan / Three Phase			
		Breast Imaging		76942	Thyroid Needle Biopsy, Ultrasound Guided (76942, 10022, 99070)
		VQ Lung Scan			
		Thyroid Therapy			
		PTE – Persantine			
		Adenoscan			

Additional Information / Remarks: _____

ORDERING PHYSICIAN SIGNATURE: _____ DATE: _____

READING PHYSICIAN SIGNATURE: _____ DATE: _____

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



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DIAGNOSTIC TESTING REQUEST FORM

REQUESTING PHYSICIAN: _____ PHONE: _____

BEST NUMBER TO SEND OR CALL RESULTS TO: FAX _____ PHONE _____

URGENCY OF TEST (circle one): TODAY TOMORROW THIS WEEK NEXT WEEK

PATIENT DEMOGRAPHICS

NAME: _____ HOME NBR: _____ CELL NBR: _____

ADDRESS: _____

DATE OF BIRTH: _____ SSAN NUMBER: _____

INSURANCE INFORMATION – PRIMARY INSURANCE

INSURED NAME: _____ POLICY NBR: _____

INSURED SSAN NUMBER: _____ INSURED DATE OF BIRTH: _____

INSURANCE CARRIER: _____ PHONE: _____

INSURANCE INFORMATION – SECONDARY / SUPPLEMENTAL INSURANCE

INSURED NAME: _____ POLICY NBR: _____

INSURED SSAN NUMBER: _____ 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.

NOTE: If all information is not received at least 2 days prior to 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.