

**OUTPATIENT SERVICE
ORDER FORM**

Patient Name: _____ Patient Phone: _____

Referring Physician: _____ Today's Date: _____

OUTPATIENT SERVICES

AREAS **Phone No.**
(Best Scheduling Hours)

- Cardiac Stress Testing.....351-2470
(M-F 7 AM-3 PM)
- Cardiac Rehab.....351-2716
(M, W, F 8 AM-7 PM)
- Echocardiography.....351-7948
(M-F 8 AM-4 PM)
- EEG.....351-2266, 2308
(M-F 8 AM-4 PM)
- EKG.....351-2291
(M-F 10 AM-4 PM)
- Holter Monitor.....351-2798
(M-F 8:30 AM-4 PM)
- Infusion Therapy.....351-2343
Fax.....351-2069
(M-Sun 8 AM-3 PM)
- Laboratory.....351-2291
(M-F 10 AM-4 PM)
- Nuclear Medicine.....351-2276, 2277
(M-F 9 AM-4 PM)
- Physical Therapy.....351-2274
(M-F 8 AM-3 PM)
- Respiratory Care.....351-2278
(M-F 7 AM-3 PM)

- X-Ray:
- Outpatient351-2297
(DAILY 8 AM-8 PM)
 - CT Scan351-2372
(M-Sa 8 AM-7 PM)
 - Ultrasound.....351-2350
(M-Sa 8 AM-7 PM)

Please use the Physical Therapy "Referral Form" to specify procedures requested.

Patient arriving for outpatient testing should report to the specific department between the hours of 7 AM – 4 PM Mon.-Fri. After 4 PM and weekends, outpatients should report to Radiology.

Test(s) and/or Services Requested:

Patient History/Diagnosis:

ICD-9 CODE: _____

Physician Signature