EMORY HEALTHCARE

P S - 1 0 7 2

DTC Misc Procedure Order
FAX orders to: 404.501.5703
Phone: 404.501.5580

Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Order Information

Diagnosis: _____

ICD CM Codes: _____
Test/Service:

☐ Thoracentesis: ☐ Right side ☐ Left side ☐ w/ Ultra Sound guidance
Labs: _____

Additional Orders: _____

☐ Ashcath Removal: ☐ Have 1% lidocaine available

☐ Port Removal: ☐ Have 1% lidocaine available ☐ Have 1% lidocaine w/ epi available

☐ Capsule endoscopy:

☐ Peg tube change:

☐ Other procedure: _____

☐ Additional orders: _____
_____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____