

Physician Imaging Outpatient Order Form

Lake Forest Hospital

1000 North Westmoreland Road
Main Entrance
Lake Forest, Illinois 60045

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nm.org

Complete and Submit with **Face Sheet** to Referral Source

Patient Name _____ Date of Birth _____ Height _____ Weight _____

Diagnosis for all ordered equipment/tests _____

EQUIPMENT

- Wheelchair
- Walker
- Hospital Bed
- Commode
- Hoyer Lift
- Other _____

RESPIRATORY

- O₂ @ _____ LPM/_____ continuous
- Nebulizer machine for home use
(See prescription for medication/frequency)

HOME HEALTH CARE

- Nurse
- Physical Therapy
- Occupational Therapy
- Speech Therapy

- Labs
- Other _____

OUTPATIENT THERAPY

- Physical Therapy
- Occupational Therapy
- Speech Therapy

OUTPATIENT TESTING

- Labs _____
- X-ray _____
- Echocardiogram (Type) _____
- EEG _____
- Stress Test (Type) _____
- MRI (Indicate Specific Anatomy) _____ Contrast: W WO W/WO
- CT (Indicate Specific Anatomy) _____ Contrast: W WO W/WO
- Other _____

MISCELLANEOUS _____

PHYSICIAN INFORMATION

Physician Name (Printed) _____ NPI _____

Phone _____

Physician Signature _____ Date _____

Primary Care Physician (If Different Than Above) _____

Phone _____ Fax _____