Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

Arkansas Children's Hospital
Referred Patient Requisition Order / Referral
Ancillary Services

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

Patient Name:
Patient Address:
Patient's Birthdate: Phone #:
Guardian's Name:
Guardian's Birthdate:
ACH Medical Record #:
Referring / Ordering MD:
Street:
City: State: Zip:

Insurance Company:
Insurance Policy Number:
Insurance Referral #:
Medicaid Policy Number:
Medicaid Referral #: (NPI)
NOTE: Non-PCP providers must have a PCP referral on file for Medicaid patients. Pre-Authorizations are REQUIRED for patient's that have any insurance outside of AR Medicaid A/B
Pre-Authorization #:
Pre-Authorization NOT REQUIRED Reference #:
Pre-Authorization Time Frame:
Requested Date of Service _____

WRITE THE TEST / PROCEDURE / SUPPLY, LOCATION, AND THE APPROPRIATE DIAGNOSIS CODE IN THE SPACES BELOW.
All orders for tests / procedures / supplies must include the diagnosis/medical reason for the test. This must be an ICD-10 Diagnosis Code. All orders for supplies must also include the quantity.

Procedure / Supply	Location / Department	Please indicate the specific diagnosis code required for the ordered test/procedure/supply. Do not use "rule out" diagnosis and avoid using "V" codes	
		ICD-10 Diagnosis (5-digit code)	Diagnosis
Example: Sweat Test	**Little Rock / Pulmonary Lab**	**J45.909**	**Asthma Unspecified**
1.			
2.			
3.			
4.			
5.			

PROVIDER(S) MAIN CONCERN:

PLEASE CHECK APPROPRIATE BOX(ES) BELOW:

■ **MRI/CT/US scans:** ☐ Perform order as written ☐ Perform per Radiologist ☐ Patient will be seen in ACH clinic/or ASC same day as radiology testing
☐ Patient has Shunt : Progammable ☐ Yes ☐ No ☐ Sedation required ☐ Speech/Language/Feeding Evaluation & Management
☐ Patient has Autism or Intellectual/Developmental disability ☐ Audiology Evaluation & Management
☐ Patient is Diabetic ☐ Patient is over 300 Lbs. ☐ 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 directly to the specified service:

				ACH Outpatient Testing/Outpatient Lab/Supplies	(501) 364-3578
Apheresis	(501) 364-2283	Day Med	(501) 364-3804	PT / OT	(501) 364-3564
Burn Treatment	(501) 364-6480	EEG	(501) 364-6281	Pulmonary Lab	(501) 364-1887
CFC - Lowell	(479) 750-0323	GI Lab	(501) 364-4658	Radiology	(501) 364-3549
CFC - Jonesboro	(870) 336-2180	Heart Station	(501) 364-5440	Sleep Lab	(501) 364-6878