ARKANSAS CHILDREN'S HOSPITAL–JONESBORO
Referred Patient Requisition Order / Referral
Ancillary Services

Phone: 870–336–2175

Fax: 870–336–2180

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

Patient Address: Phone #: Mother's First Name: ACH Medical Record #: Referring / Ordering MD: Street: City: State: Zip:	Insurance Company: Insurance Policy Number: Insurance Referral #: Medicaid Policy Number: Pre Authorization#: **Medicaid Referral#: (NPI)** **NOTE: Non–PCP providers must have a PCP referral on file for Medicaid patients.** 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 ICD9 Diagnosis Code. All orders for supplies must also include the quantity.

Procedure / Supply	Location / Department	Please indicate the specific diagnosis code requiring the ordered test/procedure/supply. Do not use "rule out" diagnoses and avoid using "V" codes	
		ICD–10 Diagnosis (5–digit code)	Diagnosis
Example: Sweat Test	**Pulmonary Lab**		**Asthma NOS**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Source Document Name: ____ Date of Document)__________________

Scribed/Transcribed for ________________________by_________________________Title_____Date_________Time_______

ORDERING PHYSICIAN/APN Printed ____

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

November 26, 2018