“Provider Order” **MUST** be presented on test date. Please arrive **15 minutes** prior to testing.

<table>
<thead>
<tr>
<th>Test Date:</th>
<th>Primary Insurance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEST:</td>
<td>Pre-Cert #: Time:</td>
</tr>
<tr>
<td>TEST:</td>
<td>Pre-Cert #: Time:</td>
</tr>
<tr>
<td>TEST:</td>
<td>Pre-Cert #: Time:</td>
</tr>
<tr>
<td>TEST:</td>
<td>Pre-Cert #: Time:</td>
</tr>
</tbody>
</table>

**DIAGNOSIS:**

**ICD CODE:**

☐ This patient is a direct admit. Orders are in CPOE.

**SPECIAL INSTRUCTIONS**

- **DO NOT EAT OR DRINK AFTER MIDNIGHT**

---

**ALL MINORS MUST HAVE PARENT OR LEGAL GUARDIAN PRESENT.**

To cancel or reschedule a test, please call scheduling at 662-293-1026 as soon as possible.

**MEDICAL OFFICE NAME:**

**PHONE #:**

**FAX #:**

**Provider Name (printed):**

**Provider Signature:**

**Date:**

**Referring Provider:**

Please include an after-hours contact # for Critical Findings:

---

**PLEASE FAX THIS ORDER AND PATIENT DEMOGRAPHIC SHEET TO SCHEDULING 662-293-4337**

Notice: This facsimile transmission and/or the documents accompanying it may contain confidential and/or privileged information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this transmission in error, please immediately notify us by telephone to arrange for return of documents. 662-293-1000 Thank you.