



611 Alcorn Drive * 662-293-1000



Parking is available in Lot #5 across from Main Entrance A

Enter through Main Entrance A and proceed to Sign In Desk.

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

Patient Name: _____ Date of Birth: _____ Phone #: _____

Form with fields for Test Date, Primary Insurance, TEST, Pre-Cert #, Time, DIAGNOSIS, and ICD CODE.

[] This patient is a direct admit. Orders are in CPOE.

SPECIAL INSTRUCTIONS

Form with a checkbox for 'DO NOT EAT OR DRINK AFTER MIDNIGHT' and several blank lines for additional instructions.

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

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