PROVIDENCE Health & Services

Providence Regional Medical Center Everett

# Scheduling Request Form

This form may be printed and populated manually,
or populated electronically then printed/emailed/faxed

## Patient Details

Patient Legal Name (First, Middle, Last): ______

Sex: Male ☐ Female ☐ Date of Birth: ____ / ____ / ____ Needs Interpreter? Yes ☐ No ☐ Language: ______

Home Phone: ( ____ ) ____ - ____ Cell Phone: ( ____ ) ____ - ____

Address: ______

## Patient Insurance Details

Insurance Name and Plan/Network: ______ Group #: ______

Subscriber Name/ID: ______ Subscriber DOB: ____ / ____ / ____

Authorization #: ______

## Service Details

Service Ordered: ______

Reason for Exam: ______

Service Date: ____ / ____ / ____ Priority: Normal ☐ STAT ☐ Patient Status: Inpatient ☐ Outpatient ☐

Ordering Provider: ______

ICD: ____ ; ____ ; ____ ; ____ ; ____ ; ____

or Diagnosis Description: ______

CPT: ____ ; ____ ; ____ ; ____ ; ____ ; ____

or Procedure Description: ______

Allergies (list all): ______

Special equipment or requests: ______

**Upon completion of form, fax to the appropriate department:**

| | | | | |
|---|---|---|---|---|
| Echo | 425-297-5950 | | Maternal Fetal Medicine Clinic | 425-304-6162 |
| Colby X-ray (radiology) | 425-297-5950 | | Breast Center Imaging | 425-258-7905 |
| Electroencephalography | 425-297-5950 | | Postpartum and Lactation Clinic | 425-258-7588 |
| Outpatient Therapy – Pacific Campus | 425-258-7406 | | Monroe Radiology | 425-297-5950 |
| Anticoagulation Clinic – (all locations) | 425-297-5221 | | Chemical Dependency - Outpatient | 425-258-7379 |
| Women & Children's Therapy | 425-258-7618 | | Radiation Oncology | 425-297-5595 |
| Pre-Admission Clinic | 425-404-5330 | | Sleep Lab – Pacific Campus | 206-215-1135 |
| Cardiac Rehabilitation – Colby MOB | 425-261-3790 | | Wound Healing and Hyperbaric Clinic | 425-297-5305 |

Provider Signature: X ______________________ Date: ____ / ____ / ____ Time: ____ : ____ AM ☐ PM ☐

Ordering Provider Signature

For Scheduling Staff Only

Appointment/Case Date: ____ /____ /_____ Appointment/Case Time: ____:_________ CSN: ______________________