FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

Service Request Form

Phone: 818-837-5660, Urgent/Stat ext: 837-5548
Urgent/Stat Phone: 818-837-5548 (physician use only)
Fax: 818-837-5712

Routine ☐ 1 ☐ 2 ☐ **Urgent** ☐ **STAT** ☐ **Retro** ☐ **PR** ☐ **CCMG** (SFV/SCV/SV All Potential Cardiac Consult/Flw up)

SERVICE REQUESTED

☐ **Consultation** ☐ **Follow-up** ☐ **Second Opinion** ☐ **Multiple Services** ☐ 2 ☐ 3

☐ Allergy	☐ GI ☐ Colon Screening	☐ Nephrology	☐ Pain Management	☐ Rad/Onc
☐ Cardiology	☐ General Surgery	☐ Neurology	☐ Perinatal/High Risk (from OB only)	☐ Rheumatology
☐ Dermatology	☐ Gyn/Onc	☐ Neurosurgery	☐ Plastic Surgery	☐ Urology
☐ ENT	☐ Hem/Onc	☐ Ophthalmology	☐ Podiatry	☐ Vascular Surgery
☐ Endocrinology	☐ Infectious Disease	☐ Orthopedics ☐ Hand Ortho	☐ Pulmonology	☐ Other: ____

OTHER SERVICES

☐ Ankle Brachial Index
☐ Auditory Diagnostic (air, bone, speech)
☐ w/tympanograms (if ETD or CHL)
☐ w/o tympanograms or prn CHL
☐ Bone Density (DEXA)*
☐ Bone Scan (nuclear medicine)*
☐ Breast Biopsy
☐ Chemotherapy
Colonoscopy (G.I. M.D. use only):
☐ Screening ☐ Diagnostic
Duplex: ☐ Arterial ☐ Venous ☐ Carotid
Specify extremity: _____
☐ EEG
☐ EGD
☐ Echocardiogram
☐ Home Health*
☐ Hospice*

☐ Hysteroscopy
☐ Injectable Meds*
☐ NCV ☐ EMG
Specify extremity _____
☐ Self-injectable Meds*
☐ with education
Sleep Study:
☐ Titration ☐ Split Night ☐ Home
Stress Tests:
☐ adenosine cardiolyte
☐ dobutamine-echo
☐ stress-cardiolyte
☐ stress-echo
☐ Surgery: _____
Therapy*:
☐ PT ☐ OT ☐ Speech

☐ Other Services (Specify):
_____
_____
_____
CPT Codes: _____
_____
_____

☐ CT Sinus w/ Medtronic Navigation Fusion Protocol*
☐ CT Stone Survey*
☐ CT* ☐ CTA*
Specify body part: _____
☐ W/o contrast
☐ W/ contrast ☐ On Metformin
☐ IV (BUN/Cr____)

☐ DME*
O_2: Liters _____
O_2 Sat _____% by: ☐ ABG or ☐ Pulse Ox
CPAP: Settings: _____
(Sleep Study Rpt Req.)
☐ Nebulizer (For drugs, follow **below**)
Senior: Attach Med R_x to SRF
Commercial: Give Med R_x to Pt. (EHR)
Other DME: _____
Patient HT: _____ WT: _____

☐ MRI* ☐ MRA*
Specify body part: _____
☐ W/o contrast
☐ W/ & W/o contrast
☐ IV (BUN/Cr____)

CLINICAL INDICATIONS

***Indicates DEA# is required**
Italicized services require questionnaire

DX: _____ ICD10: ____.____ DX: _____ ICD10: ____.____

Medical need for service request: _____

Requesting Provider's Signature: _____ Date: _____ *DEA#: _____

Clinical information to be sent to specialist: ☐ *Lab* ☐ *X-Ray* ☐ *Other:* _____

Specialty Consulting Provider: _____ *Appt. Date/Time:* _____

I chose this provider because: ☐ *MD Preference* ☐ *Discussed care w/ SPC* ☐ *Past appt. w/ SPC* ☐ *Pt. Request*

Level of Service: ☐ In-patient ☐ Observation ☐ Outpatient
Place of Service: ☐ FMG
Hospital: ☐ PHCMC ☐ PSJMC ☐ HMNMH ☐ SVH ☐ Other: ____
ASC: ☐ FEC ASC ☐ SF ASC ☐ Summit ASC ☐ Stone Ctr/Encino ASC ☐ Valley Physicians S.C.
☐ Other ASC: ____

Affix Patient Demographic Label

or provide the following information

Name: _____
Address: _____
_____
MRN: _____ **DOB:** _____
Phone: _____ ☐ Home ☐ Work
Gender: _____ FSC/INS: _____
Requesting Provider: _____

☐ Patient to call for appointment

Date Provider/Pt. Notified: _____
Date

Comments: _____
_____
_____

Pink: Audit Copy Yellow: Patient White: SCAN Under Referral*

Reference #: _____

Entered By	Site	Date