

EKG LAB ORDER FORM

Patient Name: _____ Patient Phone Number: _____
Address: _____ DOB: _____
MRN: _____ Physician: _____ Date of Service: _____
Office contact person: _____ Phone Number: _____

Please make sure that all order requirements are met before sending order or scheduling patients.

ORDER FORM REQUIREMENTS

- ☐ Patient and physician information is clearly legible.
- ☐ Test type and diagnosis are clearly selected.
- ☐ Attach your most recent clinic notes, so that we can better serve your patient.
- ☐ Make certain that TKC EKG prep instructions are given to the patient.
- ☐ Email this order form to Medicine Scheduling at domoutsideorders@uabmc.edu or fax to 205-801-8107.
- ☐ Schedule the patient via Medicine Scheduling by calling 205-801-5655.

TEST TYPE		DIAGNOSIS
<input type="checkbox"/> EKG		<input type="checkbox"/> Atrial Fibrillation 427.31
<input type="checkbox"/> Research EKG		<input type="checkbox"/> Acute MI 410.90
MONITOR	DURATION	<input type="checkbox"/> CV Disease 429.2
<input type="checkbox"/> Holter (not real-time monitoring)	<input type="checkbox"/> 24-48 hours	<input type="checkbox"/> Chest Pain 428.0
	<input type="checkbox"/> 3-7 days	<input type="checkbox"/> CHF 786.59
	<input type="checkbox"/> Greater than 7 days	<input type="checkbox"/> Palpitation 785.1
<input type="checkbox"/> 30-Day Ambulatory Telemetry Monitor (MCOT) (real-time monitoring)	<input type="checkbox"/> 3-30 days	<input type="checkbox"/> Atrial Flutter 427.32
<input type="checkbox"/> Blood Pressure Monitor B/P: _____/_____	24 hours	<input type="checkbox"/> Unspecified Conduction Disorder 426.9
		<input type="checkbox"/> Cardiac Dysrhythmia, Unspecified 427.9
		<input type="checkbox"/> Heart Transplant V42.1
		<input type="checkbox"/> Hyperkalemia 276.7
		<input type="checkbox"/> Premature Beats 427.60
		<input type="checkbox"/> Hypertension, Benign 401.1
		<input type="checkbox"/> Unstable Angina 411.1
		<input type="checkbox"/> Other: _____

NOTICE: For the clinic to bill properly and receive payment for tests you have ordered, it is critical that the diagnosis you provide is consistent with the information recorded in the patient's medical record. The Department of Health and Human Services requires that all tests ordered for Medicare beneficiaries be reasonable and necessary. If the diagnosis you provide does not support the medical necessity of the test ordered under Medicare program standards, Medicare will deny payment, and the beneficiary may be financially responsible for the test.

SERVICES TO BE CHARGED TO:

Insurance: ☐ Yes ☐ No
Clinical Trial: ☐ Yes ☐ No
Case: ☐ Yes ☐ No

Physician/Provider Signature

Date