



TRINITY MOTHER FRANCES

HOSPITALS AND CLINICS

OUTPATIENT ANCILLARY SERVICES

Phone: (903) 531-4700 x 1 or 1-877-531-4700 x 1 Fax: (903) 510-8807

APPOINTMENT CONFIRMATION	
Patient Name:	_____
Date:	_____
Time: Arrival	_____ / Test _____
Location:	_____

Date: _____ Requesting Physician: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

PATIENT NAME		DOB	SSN
Home Phone	Work Phone	Mobile Phone	Email Address (optional)
Diagnosis/Description	ICD 9 CODE		Allergies
Name of Insurance	Policy #	Precert #	

SLEEP LAB

<input type="checkbox"/> Patient Complaint: _____	SYMPTOMS: <input type="checkbox"/> Hypersomnolence <input type="checkbox"/> Insomnia <input type="checkbox"/> Leg Kicks <input type="checkbox"/> Bed Partner has Observed Apnea <input type="checkbox"/> Unknown-Request consult with Medical Director	TENTATIVE DIAGNOSIS: <input type="checkbox"/> Sleep Disorder Breathing Disorder (PLMD) <input type="checkbox"/> Restless Leg Syndrome (RLS) <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Insomnia <input type="checkbox"/> REM Related Sleep Disorder/Night Terrors	STUDY REQUESTED: <input type="checkbox"/> Diagnostic Polysomnogram (PSG only) <input type="checkbox"/> Diagnostic Polysomnogram with MSLT <input type="checkbox"/> MWT <input type="checkbox"/> Therapeutic Polysomnogram (PSG for NCPAP Titration)	PREVIOUS POLYSOMNOGRAMS (within 2 yrs): <input type="checkbox"/> Y <input type="checkbox"/> N FOLLOW UP CARE PROVIDED BY: <input type="checkbox"/> Interpreting Physician <input type="checkbox"/> Ordering Physician
Please fax H&P information along with this form.				
LABORATORY				
<input type="checkbox"/> BUN/CREATININE				
<input type="checkbox"/> GFR				
<input type="checkbox"/> Other: _____				

NEURODIAGNOSTICS

EEG Sleep Deprived Ambulatory
 Somatosensory Study: UE LE VER BAER
 Other: _____

STRESS LAB/EKG

Cardiolyte Dobutamine Adenosine
 EKG _____ Hr Holter Monitor
 Echocardiogram Pedi (18 & under)
 Other: _____
 Interpreting MD: _____

PULMONARY

Pulmonary Function Test
 Methylocholine Challenge
 ABG
 Other: _____
 Interpreting MD: _____

ROSS BREAST CENTER

Bone Density
 Screening Mammogram
 Diagnostic Mammogram
 Other: _____

NUCLEAR MEDICINE

Bone Scan Three Phase Spect
 Cardiac Scan
 Gastric Emptying Scan
 HIDA Scan CCK: Y N
 Liver/Spleen Scan
 Lung/VQ Scan
 Other: _____

Meckel's Diverticulum
 MUGA Scan
 Renal Scan w/Lasix Washout
 Thyroid Uptake and Scan
 Thyroid Uptake Only

VASCULAR LAB - HEALTHPARK PLAZA

Carotid Ultrasound
 Venous Ultrasound
 Arterial Flow Studies
 Aortic Duplex
 Renal Duplex
 Mesenteric Duplex
 AV Fistula-Hemodialysis Duplex
 Arterial Bypass Duplex

INTERVENTIONAL RADIOLOGY

Arthrogram _____ R L
 Venogram Arm R L
 Arteriogram _____
 Other: _____

CT SCAN

*** CONTRAST:** YES NO
 Abdomen Abd/Pelvis Pelvis
 Chest Nodule
 Head Head/IAC IAC Orbits
 Biopsy: Liver/Lung/Renal
 Misc Biopsy _____

Facial Bones
 Neck Soft Tissue
 Sinuses
 Spine: Cervical/Thoracic/Lumbar
 CTA _____
 Other: _____

ULTRASOUND

Abdomen Abdomen/Pelvis Pelvis Carotid
 Abdomen/Mesenteric Doppler
 Arterial UE LE Left Right
 Biophysical Profile BPP Twins
 Biopsy: Liver Thyroid Renal
 Other: _____

Obstetrical OB Twins
 Renal Testicular Thyroid
 Paracentesis Thoracentesis R L
 Venous UE LE Left Right

MRI

*** GAD:** YES NO
 Spine: Cervical/Thoracic/Lumbar/Cord Screen
 Brain ATTN: IAC/Orbits/Pituitary/Sinuses
 Abdomen Abdomen/Pelvis Pelvis
 Brachial Plexus
 MRCP

Neck Soft Tissue
 UE Left Right _____
 LE Left Right _____
SEDATION: PO/IM/MGMT BY CRNA
 MRSA _____
 Other: _____

DIAGNOSTIC RADIOLOGY

Spine: Cervical/Thoracic/Lumbar
 Upper Extremity _____ R L
 Lower Extremity _____ R L
 IVP IVP W/ CT Cuts
 Lumbar Puncture CSF Y N
 Other: _____

Chest Ribs KUB
 Facial Bones Orbits Sinuses
 Barium Swallow/Speech Y N
 Myelogram Cervical/Thoracic/Lumbar
 Upper GI Upper GI w/ Small Bowel Series

PHYSICIAN SIGNATURE: _____ Comments: _____

Appointment Location Preference:

Mother Frances Tyler/Jacksonville The Ross Breast Center North Park Plaza Mobile Services: Mammography/MRI

Would you like P1C to contact your patient with appointment information? YES NO



Date: _____

TRINITY MOTHER FRANCES

HOSPITALS AND CLINICS

SPECIALIST REFERRAL

To Schedule Consultation Appointments, please FAX completed form, copy of insurance card and clinicals to: (903) 525-1459.

Same day or next day appointment, please call (903) 531-4700 x 2 or 1-877-531-4700 x 2.

Requesting Physician: _____

Office Contact: _____

Physician Signature: _____

Office Phone: _____ Office Fax: _____

Patient Name: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
DOB: _____	SS#: _____	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
Address: _____		City: _____	State: _____ Zip: _____
Phone #: _____	Cell #: _____	Alternate Contact #: _____	
<input type="checkbox"/> Medicare <input type="checkbox"/> Commercial Insurance Insurance Name: _____			
Policy #: _____	Group #: _____	Insurance Phone #: _____	

Refer to Specialist: Dr. _____ <OR> choose from the Specialties listed below:

<input type="checkbox"/> Allergy	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Audiology	<input type="checkbox"/> Genetics	<input type="checkbox"/> Oncology	<input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Cardiology	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Orthopaedics	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Cardio-Thoracic Surgery	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pain Mgmt/Rehab	<input type="checkbox"/> Urology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Dietary	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Other _____
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Podiatry	
<input type="checkbox"/> ENT	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Pulmonology	
<input type="checkbox"/> Family Practice	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Psychiatry/Behavioral Medicine	

Diagnosis/ICD9 Code: 1) _____ 2) _____ 3) _____

Urgency: 2-3 Days 1-2 Weeks Next Available

Same day or next day appointment, please call (903) 531-4700 x 2 or 1-877-531-4700 x 2.

Appointment Preference: Monday Tuesday Wednesday Thursday Friday Any Day
 8a - 10a 10a - 12p 1p - 3p 3p - 5p Any Time

Would you like P1C to contact your patient with appointment information? YES NO

Are we allowed to give appointment information to any other family member/guardian?

If so, please list names: _____

May we leave appointment information on answering machine? YES NO

Comments: _____

<i>Completed Appointment Information (for P1C use only)</i>	
Insurance Referral/Auth #: _____	
Patient has appointment with: _____	
Appt Date: _____	Appt Time: _____
Patient Contacted: <input type="checkbox"/> By Phone <input type="checkbox"/> By Mail Records Faxed: _____	