

PHONE: 405.271.5918

## **Echo Lab Services Referral Request**

Attn: Scheduling Team Tel: 405.271.5918 – Option 1

## FAX COMPLETED REQUEST TO: 405.271.1162

(Please Print)

Patient Information															
Last Name					First Name			MI	Date of Birth		Age	M/F			
Street Address						City					State	Zip Code			
											State	210 600	-		
Parent/Guardian Name						F	Relationship to Patient Preferre			ed Contact Number: 🗌 Cell 🔲 Home					
Orderin	g Prov	vider	Inforr	matio	n										
Full Name								MD DO NP PA							
Ordening Previden Signature															
Ordering Provider Signature								Office Staff Contact Name and Follow-Up #							
Practice Na	ame and	Addres	s												
To avoid	delays i	n orde	r proce	essing,	NP's and P	A's are	reques	ted to pr	ovide the na	me of th	eir super	vising MD	/DO belo	w.	
Supervising MD/DO Name											Contact #: Cell Office Phone				
Echo Se	Echo Service Requested (check the appropriate box below)														
Т	Transthoracic Echocardiogram with or without Congenital Anomaly (CPT 93303-93308 + 93320-93325)														
List the	List the key clinical indications/symptoms that support the medical necessity for the requested services.														
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