RAPID ENROLLMENT REQUISITION FORM

Fax this form to (856) 310-5606

LOURDES MEDICAL ASSOCIATES

Phone: (856) 323-1253

Name:

Patient Phone #: Insurance Name/ ID#:

Diagnosis:

Rule Out:

Previous testing relating to this Dx: (attach report/clinical)

Referring Physician:

Treatment Example: (Medications/ Physical Therapy, Etc.)

Duration:

Facility: ❍ OLLMC ❍ LMCBC ❍ LourdesCare at CH
❍ LourdesCare at Van Sciver ❍ Centennial Surgical ❍ Other

CONSULT WITH SPECIALISTS

❍ Cardiology ACC ❍ Cardiology SJHG ❍ Endocrinology ❍ Gastroenterology
❍ Hepatology ❍ Neurology ❍ Ob-Gyn ❍ Orthopedics
❍ Pulmonary ❍ Infectious Disease ❍ Sports Medicine ❍ Physical Therapy
❍ Aquatic Therapy ❍ Occupational Therapy ❍ Hand Therapy
❍ Transplant-

Requested Physician:

CONSULT WITH SURGERY

❍ Bariatric ❍ Breast ❍ Colorectal ❍ Digestive ❍ General
❍ Hernia ❍ Ob-Gyn ❍ Orthopedics ❍ Skin Cancer ❍ Thyroid
❍ Vascular ❍ Wound Care

Requested Physician:

OTHER CONSULTS

Consult with: Phone #:

Other:

Patient Availability for appointment/Test:

Representative Completing Form: Number of pages:

Physicians' Signature: Date:

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RADIOLOGY SERVICES
RAPID ENROLLMENT REQUISITION FORM

Fax this form to (856) 310-5606

LOURDES MEDICAL ASSOCIATES

Phone: (856) 323-1253

Medical Record # Date:

Patient Name: DOB:

Patient Phone: Insurance Name/ID:

Diagnosis:

Rule Out:

Previous testing relating to this Dx (attach report/clinical):

Referring Physician:

Treatment Example: (Medications/ Physical Therapy, Etc.)

Duration:

Facility: ❍ **Our Lady of Lourdes Medical Center** • 1600 Haddon Ave., Camden NJ 08103

❍ **Lourdes Medical Center • 218** A Sunset Road, Willingboro, NJ 08046

❍ **Centennial Surgery Center** • 502 Centennial Blvd, Suite 1, Voorhees, NJ 08043

❍ **Lourdes Care at Cherry Hill (LCCH)** • 1 Brace Road, Cherry Hill, NJ 08034

Treatment Type:

❍ CTA Scan of:	❍ With contrast	❍ Without Contrast
❍ CT Scan of:	❍ With contrast	❍ Without Contrast
❍ CT-Calcium Scoring	❍ With contrast	❍ Without Contrast
❍ MRI of:	❍ With contrast	❍ Without Contrast
❍ MRA of:	❍ With contrast	❍ Without Contrast
❍ MRI Arthrograms		
❍ MRI Entertgraphy		
❍ MRCP		
❍ MSK Ultrasound		
❍ Mammogram	❍ Routine	❍ Diagnostic
❍ Dexa		
❍ Bone Scan		
❍ X-rays – Regular of:		
❍ Utrasound of:		
❍ Sleep Study:		
❍ Other: _____		

Patient availability for appointment/test:

Representative completing form: Number of total pages:

Physicians' Signature: Date:

Rapid Enrollment Testing Requisition Form

Fax this form to Precert Department at (856) 673-1328

LOURDES CARDIOLOGY

Phone: (856) 673-1329

❍ South Jersey Heart Group ❍ Associated Cardiovascular Consultants ❍ No Preference

Patient Name:	
SS#:	DOB:
Patient Phone #:	Ins Name/Ins ID#:
Referring Physician:	Phone #:
NPI:	Copy To:

Diagnosis:

Reason for test request:

Last BP:	Diabetic: ❍ Yes ❍ No	Tobacco Use: ❍ Yes or ❍ No
Height:	Weight:	

Has patient had a lipid panel performed: ❍ Yes (*fax a copy*) or ❍ No

Check all that apply:

❍ Abnormal EKG (send interpreted and signed copy)
❍ Discharged from hospital for a cardiac condition within the last 8 weeks (fax discharge summary)
❍ Recent abnormal cardiac testing, further testing needed (fax copy of abnormal test)
❍ Known/ documented CAD with new symptoms. (fax note documenting symptoms)
Strong clinical suspicion for CAD despite normal studies
❍ Asymptomatic patient scheduled for non-cardiac surgery needing testing for clearance
Type of surgery and date needed:_____

Was this test performed previously? ❍ Yes (*fax a copy*) ❍ No

Please put all related codes on referral

CARDIAC NUCLEAR

❍ Cardiolite/Treadmill Stress Test w/Wall Motion & Ejection Fraction (**CPT 78452 & 93017**)
❍ Adenosine/Pharmacologic Stress Test w/Wall Motion & Ejection Fraction (**CPT A9502 & 93017 & 78452**)
❍ MUGA Heart Scan (nuclear ejection fraction)
❍ (**CPT 78472**) Planar Single Study ❍ (**CPT 78494**) Heart Image Spec
❍ (**CPT 78473**) Gated Heart Multiple

CARDIAC ULTRASOUND

❍ 2D Echocardiogram with Doppler/Color Flow (**CPT 93306**)
❍ Stress Echocardiogram (**CPT 93351**)
❍ Carotid Doppler (**CPT 93880**)

OTHER

❍ ECG Treadmill Stress Test (**CPT 93017**)
❍ Holter Monitor (**CPT 93227**)
❍ Cardiac Event Monitor Non-Loop (**CPT 93014**)
❍ ECG Resting (**CPT 93000**)
❍ Cardiac Event Monitor Loop (**CPT 93272**)

Physician's Signature: Date:

Unable to Process Test Order

LOURDES CARDIOLOGY

LOURDES MEDICAL ASSOCIATES

Date: Fax:

Patient: DOB:

Referring Physician:

Primary Physician:

Unfortunately, we were unable to schedule the test/appointment your office requested for the following reason:

❍ Unable to reach patient by phone number:_____

❍ Left several messages with no response

❍ Patient went to another facility

❍ Unable to read script

❍ Need Insurance ID number_____

❍ Please fax the following clinical information that is required to start a pre-cert request with your patient's health plan: last office visit note, interpreted abnormal EKG, abnormal labs, and any other prior testing in the last year.

❍ Other/Notes:

What further action would you like us to take?

❍ Contact patient at this alternate phone number:_____

❍ Cancel test order

❍ Change test order to:_____

❍ Faxed by:_____

Please return this form via fax to: ❑ (856) 310-5606 ❑ (856) 673-1328

Questions please feel free to call: ❑ (856) 796-9386 ❑ (856) 673-1329

LOURDES
MEDICAL ASSOCIATES

Direct Access Colonoscopy (DAC) Requisition Form

Fax this form to: (609) 835-3628

Call: (609) 835-3624

Medical Record # (if applicable): _____ **Date: _____/_____/_____**

Patient Name: _____ DOB: _____/_____/_____

Patient Preferred Phone #: _____

Insurance Name/ ID #: _____

Procedure: SCREENING COLONOSCOPY

Criteria: Age, Personal History Colon Polyps, Family History Colon/ Rectal Cancer, Inflammatory Bowel Disease

Procedure Locations: OLOL-Camden, OLOL- Burlington & Centennial Surgery Center-Voorhees

Referring Physician:_____

Office Phone #:_____ Fax #:_____

____/____/____ Date of Previous Colonoscopy if applicable/available

☐ Attached Reports/Biopsy Result if applicable/available

____/____/____ Date of Last EKG (if applicable)

☐ Attached EKG

☐ Attached Relevant Medical Reports (Diabetes, Cardiac History)

******DAC Hours for interviews: 7:30AM – 3:30PM, Monday-Friday******

Patient availability for telephone interview: _____

Representative Completing Form: _____ Number of Pages: _____

Physician's Signature: _____ Date: _____/_____/_____

Printed Physician Name:_____