THE UNIVERSITY OF KANSAS HEALTH SYSTEM

4000 Cambridge Street
Kansas City, Kansas 66160

**Referral Request/Outpatient Order**

**Do not write in this box**

DT0017
Orders

**Name:**______________________________

**DOB:**______________________________

**MRN:**______________________________

Patient Phone: ______________________________ Alternate Patient Phone: ______________________________

**Referring Provider Information:**

Clinic RN:______________________________Fax: ______________________________

Clinic RN E-mail: ______________________________ Phone: ______________________________

Ordering Physician: ______________________________ Pager/Phone: ______________ NIP: ______________

**Physician Signature (Required):** ______________________________ **Date:** ______________ **Time:** ______________

**Reason for Referral/Order:**

**Service Requested:**

☐ Procedure ☐ Consult Only ☐ Consult & Treat ☐ 2nd Opinion

Does the patient need an interpreter: ☐ Yes ☐ No Type: ______________ Is the patient able to sign: ☐ Yes ☐ No

Is the patient coming from a nursing facility ☐ Yes ☐ No

**Procedure Requested (Required):** ______________________________

Diagnosis: ______________________________ ICD-10: ______________________________

Reason for Referral: ______________________________

**Pathology/Cytology Test Requested (Required, if applicable for order):**

☐ Flow Cytometry ☐ Cytogenetic ☐ Culture ☐ Cytology ☐ Other: ______________________________

☐ Molecular Test ☐ KRAS ☐ ALK-FISH ☐ BRAF PAR ☐ BRAF Melanoma ☐ Surgical Pathology ☐ EGFR

**Lab Fluid Testing (Required, if applicable for order):**

☐ PH ☐ Culture and Sensitivity ☐ Gram Stain ☐ Albumin ☐ Cell Count ☐ Anaerobic ☐ Aerobic ☐ Cell Block ☐ Cytology

☐ Catheter Tip Culture ☐ Other: ______________________________

*********Documentation listed below is required to be faxed with this order form**********

☐ Patient information (copy of patient demographics/face sheet)

☐ Recent/relevant History and Physical, MRI/CT/X-Ray results

☐ Recent/relevant imaging location: ☐ PACS ☐ Other: ______________________________

☐ Recent/relevant lab results (less than 30 days old)

**IR Use Only:**

Appointment Date and Time: ______________________________

Location: ☐ ICC ☐ Bell ☐ Cambridge

Comments: ______________________________

Reviewed by: ______________________________ Date: ______________

**Fax 913-588-8376 IR Scheduling Phone 913-588-1030**
**# of Pages Faxed___________ Date Faxed: ___________**



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