DEPARTMENT OF RADIOLOGY AT NEWYORK-PRESBYTERIAN

WEILL CORNELL IMAGING at NYP | WCMC RADIOLOGY | NYP-LOWER MANHATTAN HOSPITAL

CHANGE ORDER FORM

Application: Fill out this side of the form if there is a **complete change** in order or an additional study needs to be ordered. (i.e., CT is more optimal than MRI; CT pelvis added on to CT abdomen; etc.)

Directions: (1) Fill out "Change Order" form
(2)) Fax the completed form to referring MD office
(3)) Scan form into patient's record in Medicalis and update exam scheduled
(4)) Follow-up with referring MD office to obtain a new order
(5)) If necessary, submit form for insurance pre-authorization.
(6) RESEARCH STATUS CHANGE: Support staff authorized to document new research info obtained, scan and fax as per above. Also, link exam to EPIC Research case. No new order necessary if no change in original clinical exam.

PATIENT INFORMATION

PATIENT _____

APPT. DATE _____ TIME _____

MRN _____ DOB _____

REFERRING PHYSICIAN NAME _____

REFERRING PHYSICIAN PHONE # _____

REFERRING PHYSICIAN FAX # _____

CHANGE ORDER INFORMATION

Please be sure to complete all fields in this section

DATE _____

REFERRING OFFICE CONTACT NAME _____

ORIGINAL ORDER _____

NEW ORDER _____

REASON FOR CHANGE _____

RADIOLOGIST/ NURSE/ TECHNOLOGIST:

NAME: _____ **SIGNATURE:** _____

Authorization Department Only

Insurance Name & ID #	*Original CPT code:* *Revised CPT code:*
Authorization#	*New Authorization# (if applicable)*
Contact @ Physician's Office:	*Comments:*

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VERBAL ORDER FORM

Application: Complete this side of the form when a patient presents without an order and the referring MD has not faxed an order. Also use when there is a **slight modification** of order. (i.e. "without and then with contrast" instead of "with" contrast; unilateral mammogram instead of bilateral mammogram; etc.)	**Directions:** (1) Fill out "Verbal Order" form (2) Fax the completed form to referring MD office (3) Scan form into patient's record in Medicalis and update exam scheduled (4) Follow-up with referring MD office to obtain a new order (5) If necessary, submit form for insurance pre-authorization

PATIENT INFORMATION

PATIENT _____

APPT. DATE _____ TIME _____

MRN _____ DOB _____

REFERRING PHYSICIAN NAME _____

REFERRING PHYSICIAN PHONE # _____

REFERRING PHYSICIAN FAX # _____

VERBAL ORDER INFORMATION

Please be sure to complete all fields in this section

DATE _____

REFERRING OFFICE CONTACT NAME _____

EXAM REQUESTED _____

_____

REASON FOR EXAM _____

SENIOR PATIENT COORD./PATIENT ACCESS COORD./RADIOLOGIST/ NURSE/ TECHNOLOGIST

NAME: SIGNATURE:

_____

Authorization Department Only

Insurance Name & ID #	*Original CPT code:* *Revised CPT code:*
Authorization #	*New Authorization # (if applicable)*
Contact @ Physician's Office:	*Comments:*