

TELEPHONE OUTPATIENT ORDER CONFIRMATION FORM

To: _____

REGARDING:

Patient Name: _____ Date of Birth: _____ MRN: _____

**THIS IS TO CONFIRM THE TELEPHONE/CHANGED ORDER FOR SERVICES OBTAINED AT
 RUTLAND REGIONAL MEDICAL CENTER. PLEASE SIGN AND RETURN TO RRMCC.**

Any questions concerning this form, please contact the department providing this service.
 Thank you for your cooperation.

Provider Signature: _____ Date/Time: _____

This form is part of your patient's permanent medical record.

Please fax to the Ancillary Department's Reception Desk within 48 hours (fax numbers provided below).

Date of Provider Telephone Order: _____ Exam(s): _____

Authorized by: _____ Copies to: _____

Date of Test/Exam(s): _____ Reason for Test/Exam: _____

Call Results Phone Number: _____ Information taken by: _____

Your Patient Had:

- | | |
|--|--|
| <input type="checkbox"/> Diagnostic Imaging Services – fax to 747-6200 | <input type="checkbox"/> Incomplete orders |
| <input type="checkbox"/> Lab Services – fax to 747-3631 | <input type="checkbox"/> Incorrect ordered test/exam |
| <input type="checkbox"/> Outpatient Rehab Services – fax to 747-3856 | <input type="checkbox"/> Additional test/exams |
| <input type="checkbox"/> Other Services: _____ | <input type="checkbox"/> Ordered test/exams changed/added by Radiologist |
| Fax: _____ | <input type="checkbox"/> Other: _____ |

Telephone order successfully read back.

Signature: _____ Date/Time: _____