Merrimack Valley Hospital
A New Day. A New Vision for the Valley.

PHYSICIAN BOOKING & ORDER FORM
*Report to registration

140 Lincoln Avenue
Haverhill, MA 01830
978 374-2000
fax 978 521-8122

__ Diagnostic testing **__ Input (Admit)** **__ SDC**
__ Observation **__ Minor surgery**
__ Endoscopy

(Please Print)

PATIENT'S NAME_____
LAST FIRST MI
ADDRESS_____
STREET CITY STATE ZIP CODE
SS #_____TELEPHONE _____DOB_____

SYMPTOMS/DIAGNOSIS_____

TESTING DATE & TIME _____

MEDICAL NECESSITY FOR TESTS_____

ALLERGIES_____
LATEX ALLERGY YES___ NO____

INSURANCE_____

SUBSCRIBER_____ **APPROVAL #**_____

MEDICAID PCC#_____
_____

_____*WORKER'S COMP:*
*INJURY DATE*_____*EMPLOYER*_____
PHONE: _____

___ *AUTO ACCIDENT:*
*INJURY DATE*_____ *INSURANCE AGENT*_____ *PHONE:*_____
_____

MEDICAL IMAGING
__X-ray (specify):_____
__CT (specify)_____
__MRI (specify)_____
__Nuclear medicine (specify) _____
__Barium enema __IVP __Upper GI __Other (please specify):_____

MAMMOGRAPHY
__Screening __Diagnostic __Ultrasound __Nuclear medicine (specify)_____

NON-INVASIVE THERAPY
__Chest x-ray __Pulse oximetry __PFT Screen __PFT Complete __ABG __EEG
__EKG to be read by: _____MD
__Physical therapy/pre-op consult __Speech therapy __Treatment (specify)_____

PHYSICIAN'S COMMENTS:_____

PHYSICIAN'S SIGNATURE_____