



**SCHEDULING REQUEST**

**Phone: 541-382-9383**

**Fax: 541-382-6635**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB : \_\_\_\_\_  
**(Please Print)**

Social Security # \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_  
**(Please Print)**

Office Contact \_\_\_\_\_

Test/Procedure Requested \_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Codes: \_\_\_\_\_

Procedure: \_\_\_\_\_ CPT Codes: \_\_\_\_\_

Physician Signature/Stamp \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Labs Requested \_\_\_\_\_

**Insurance Information**

Insurance Company: \_\_\_\_\_

Authorization #: \_\_\_\_\_