



Pediatric Scheduling Order Form
For appointments Call 970-544-1392 or Fax to 970-544-1589

****USE DIAGNOSES ON BACK OF FORM****

Form with fields for Patient Name, DOB, Home Phone, Work Phone, Cell Phone, Insurance, Physician Signature, Dated, Timed, Requested Date/Time for Testing, Other Physician to receive copy of results, Medications reconciled in the Physician's office.

Table with 4 columns: RADIOLOGY, MRA SCAN, LABORATORY, LABORATORY. Contains various medical test options with checkboxes.

Advanced Beneficiary Notice (ABN) – Scheduler Use Only: ABN Passed or Failed Failed Procedures:

Patient Name: _____

Diagnosis	ICD-10	Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Abdomen bloat/distention	R14.0	<input type="checkbox"/> Malaise	R53.81	<input type="checkbox"/> Undescended testes, unilateral	Q53.10
<input type="checkbox"/> Acne	L70.9	<input type="checkbox"/> Multiple Sclerosis	G35	<input type="checkbox"/> Undescended testes, bilateral	Q53.20
<input type="checkbox"/> Acne, infantile	L70.4	<input type="checkbox"/> Obesity (BMI of:)	E66.9	<input type="checkbox"/> Urticaria	L50.9
<input type="checkbox"/> Allergies, to animals	J30.81	<input type="checkbox"/> OM: <input type="checkbox"/> Left <input type="checkbox"/> Right	H65.19x	<input type="checkbox"/> Urticaria, allergic	L50.0
<input type="checkbox"/> Allergies, to pollen	J30.1	<input type="checkbox"/> acute <input type="checkbox"/> chronic	H65.49x	<input type="checkbox"/> URI	J06.9
<input type="checkbox"/> Allergies, food:		<input type="checkbox"/> nonsuppurative <input type="checkbox"/> suppurative	H66.xxx	<input type="checkbox"/> UTI	N39.0
<input type="checkbox"/> Allergic reaction, unknown sub	T78.40xA	<input type="checkbox"/> Pharyngitis, acute	J02.9	<input type="checkbox"/> UTI, newborn	P39.3
<input type="checkbox"/> Anemia, iron deficiency	D50.9	<input type="checkbox"/> Pharyngitis, strep	J02.0	<input type="checkbox"/> Viral Syndrome	B34.9
<input type="checkbox"/> Anemia, unspecified	D64.9	<input type="checkbox"/> Pharyngitis, viral	J02.8	<input type="checkbox"/> Vomiting	R11.11
<input type="checkbox"/> Anemia, newborn	P61.4	<input type="checkbox"/> Routine exam w/o abnormal	Z00.129	<input type="checkbox"/> Vomiting with nausea	R11.2
<input type="checkbox"/> Anemia, newborn, premature	P61.2	<input type="checkbox"/> Routine exam with abnormal	Z00.121		
<input type="checkbox"/> Anemia, newborn due to ABO	P55.1	<input type="checkbox"/> RSV, bronchitis	J20.5		
<input type="checkbox"/> Anemia, newborn due to Rh	P55.0	<input type="checkbox"/> RSV, bronchiolitis	J21.0		
<input type="checkbox"/> Anorexia	R63.0	<input type="checkbox"/> RSV, croup	J05.0/B97.4		
<input type="checkbox"/> Bronchiolitis, acute	J21.9	<input type="checkbox"/> Injury <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Tear <input type="checkbox"/> Pain		<input type="checkbox"/> Personal history of:	
<input type="checkbox"/> Bronchiolitis, acute due to RSV	J21.0	<input type="checkbox"/> Acute - <input type="checkbox"/> Initial <input type="checkbox"/> Subseq <input type="checkbox"/> Sequela		<input type="checkbox"/> Family history:	
<input type="checkbox"/> Bronchitis, acute	J20.9	<input type="checkbox"/> Chronic/Old <input type="checkbox"/> Left <input type="checkbox"/> Right			
<input type="checkbox"/> Bronchitis, chronic	J42	<input type="checkbox"/> Arm <input type="checkbox"/> Meniscus			
<input type="checkbox"/> Bronchospasm	J98.01	<input type="checkbox"/> Ankle <input type="checkbox"/> Patella			
Conjunctivitis, <input type="checkbox"/> Left <input type="checkbox"/> Right	H10.3x	<input type="checkbox"/> Chest <input type="checkbox"/> Rib			
<input type="checkbox"/> acute <input type="checkbox"/> chronic	H10.401x	<input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder			
<input type="checkbox"/> Constipation	K59.00	<input type="checkbox"/> Finger, digit # <input type="checkbox"/> Sternum		Other diagnoses: <input type="checkbox"/> Left <input type="checkbox"/> Right	
Cough: <input type="checkbox"/> acute <input type="checkbox"/> subacute <input type="checkbox"/> chronic		<input type="checkbox"/> Foot <input type="checkbox"/> Thigh		<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	
<input type="checkbox"/> cough syncope <input type="checkbox"/> other specified		<input type="checkbox"/> Forearm <input type="checkbox"/> Toe, digit #		<input type="checkbox"/> Initial <input type="checkbox"/> Subsequent <input type="checkbox"/> Sequela	
<input type="checkbox"/> Croup	J05.0	<input type="checkbox"/> Hand <input type="checkbox"/> Wrist			
<input type="checkbox"/> Dermatitis	L30.9	<input type="checkbox"/> Head <input type="checkbox"/> Other:			
<input type="checkbox"/> Diarrhea, infectious	A09	<input type="checkbox"/> Hip			
<input type="checkbox"/> Diarrhea, non-infectious	R19.7	<input type="checkbox"/> Knee			
<input type="checkbox"/> Diarrhea, neonatal	P78.3	<input type="checkbox"/> Leg, upper			
<input type="checkbox"/> Dysuria	R30.0	<input type="checkbox"/> Leg, lower			
<input type="checkbox"/> Eczema	L30.9	Abdomen <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ			
<input type="checkbox"/> Enteritis, viral	A08.4	<input type="checkbox"/> Epigastric <input type="checkbox"/> Periumbilical			
<input type="checkbox"/> Enteritis, bacterial	A04.9				
<input type="checkbox"/> Epistaxis	R04.0	<input type="checkbox"/> Screening, developmental d/o	Z13.4		
<input type="checkbox"/> Fatigue	R53.83	<input type="checkbox"/> Screening, diabetes	Z13.1		
<input type="checkbox"/> Fever	R50.9	<input type="checkbox"/> Screening, PKU	Z13.228		
<input type="checkbox"/> Fever, newborn	P81.9	<input type="checkbox"/> Screening, thyroid	Z13.29		
<input type="checkbox"/> Headache	R51	<input type="checkbox"/> Screening for:			
<input type="checkbox"/> Hypoxemia	R09.02	<input type="checkbox"/> Short Stature	R62.52		
<input type="checkbox"/> Hypoxemia, newborn	P84	<input type="checkbox"/> Sinusitis, acute	J01.90	COVID-19	
<input type="checkbox"/> Influenza, respiratory	J11.1	<input type="checkbox"/> Sinusitis, chronic	J32.9	<input type="checkbox"/> Actual/suspected exposure – Z20.822	
<input type="checkbox"/> Influenza, gastrointestinal	J11.2	<input type="checkbox"/> Sore throat	J02.9	<input type="checkbox"/> Confirmed virus infection – U07.1	
<input type="checkbox"/> Jaundice, neonatal	P59.9	<input type="checkbox"/> Sore throat, strep	J02.0	<input type="checkbox"/> History of infection – Z86.16	
<input type="checkbox"/> Jaundice, neonatal, prematurity	P59.0	<input type="checkbox"/> Tonsillitis, acute	J03.90	<input type="checkbox"/> Pneumonia due to COVID-19 – J12.82	
<input type="checkbox"/> Lymphadenopathy, generalized	R59.1	<input type="checkbox"/> Tonsillitis, chronic	J35.01	<input type="checkbox"/> Sequelae of infection – B94.8	
		<input type="checkbox"/> Tonsillitis, recurrent	J03.91	<input type="checkbox"/> Antibody response testing – Z01.84	
<input type="checkbox"/> Lymphadenopathy, localized	R59.0	<input type="checkbox"/> Tonsillitis, strep	J03.00	<input type="checkbox"/> Post Covid condition – U09.9	

This is the back page of Aspen Valley Hospital's Pediatric Scheduling form – please submit both front (tests) and back (diagnosis).