COMMON EXAMS

This form is part of the patient's medical record and must be completed for referral

Date of Referral _____ Referring Provider Name _____

Patient Name (First, MI, Last) _____ DOB_____

Patient Home Phone _____ Cell_____

SSN _____ Translator Needed (language)_____

Written Diagnosis/Reason/Symptom for Exam(s) **REQUIRED**

ICD-10 CODE:_____ **ICD-10 CODE:**_____

X-RAY

NO APPOINTMENT NECESSARY
Specify additional views:

❑ Chest			
❑ Sinuses			
❑ Cervical Spine			
❑ Thoracic Spine			
❑ Lumbar Spine			
❑ Scoliosis			
❑ KUB			
❑ Abdomen Series			
❑ Pelvis only			
❑ Pelvis w/Lateral Hip	**lt**	**rt**	**bilat**
❑ Hips	**lt**	**rt**	**bilat**
❑ Shoulder	**lt**	**rt**	**bilat**
❑ Ribs	**lt**	**rt**	**bilat**
❑ Elbow	**lt**	**rt**	**bilat**
❑ Forearm	**lt**	**rt**	**bilat**
❑ Wrist	**lt**	**rt**	**bilat**
❑ Hand	**lt**	**rt**	**bilat**
❑ Finger	**lt**	**rt**	**bilat**
❑ Knee	**lt**	**rt**	**bilat**
❑ Tib/Fib	**lt**	**rt**	**bilat**
❑ Ankle	**lt**	**rt**	**bilat**
❑ Foot	**lt**	**rt**	**bilat**
❑ Toe	**lt**	**rt**	**bilat**
❑ Other_____	**lt**	**rt**	**bilat**

FLUOROSCOPY

- ❑ Esophagram (Barium Swallow)
- ❑ Upper GI ❑ IVP
- ❑ Small Bowel
- ❑ Barium Enema ❑ w/Air Contrast
- ❑ Arthrogram
- ❑ Other_____

BONE DENSITOMETRY (DEXA)

- ❑ Spine & Femur
- ❑ Other (Specify) _____

MAMMOGRAPHY

PLEASE USE THE BREAST IMAGING ORDER FORM

ULTRASOUND

- ❑ Vascular **(Specify)** _____
  - ❑ Arterial ❑ Venous
- ❑ AAA Screen (Medicare IPPE exam)
- ❑ Abdomen - Complete
- ❑ Abdomen - Limited (Area of interest?)

  _____
- ❑ Superficial Soft Tissue (Area of interest?)

  _____
- ❑ Extremity **lt rt (Specify)**_____
- ❑ Renal
- ❑ Pelvic (transabdominal &/or transvaginal as needed for diagnostic visualization)
- ❑ Pelvic - Limited **(Specify)** _____
- ❑ Pelvic - Transvaginal only
- ❑ OB ___Multiple ___ High Risk
  ___Follow-up ___ Limited
  - ❑ < 14 weeks complete (transvaginal as needed for visualization)
  - ❑ > 14 weeks complete
- ❑ Biophysical Profile
- ❑ Thyroid / Neck
- ❑ Testicular / Doppler
- ❑ **Other (Specify)**_____

PRIOR EXAMS

_____ _____
Date of Service Facility Location
Other last name: _____

Appointment:

Date _____Check-in Time _____

Appointment Time _____

- ❑ Call patient to schedule
- ❑ Patient will call to schedule

Reports:

- ❑ Call STAT _____
- ❑ Fax STAT_____
- ❑ Fax Routine_____

Images: ❑ CD ROM ❑ Web PACS

❑ Send with patient ❑ Send to provider

Additional Reports to PCP:

_____

Insurance(s): _____

Pre-Authorization # _____

Injury Date _____Claim #_____

DIAGNOSTIC IMAGING NORTHWEST

An Alliance of TRA Medical Imaging and MultiCare Health System

Scheduling: **253-841-4353**
FAX: **253-446-3973**
Locations: (See maps on back)
Tax ID 26-1166816

REFERRING PROVIDER SIGNATURE

✍ _____

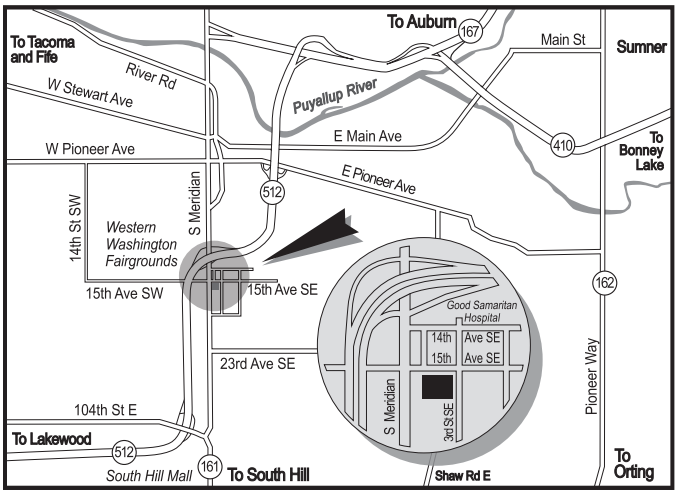
DIAGNOSTIC IMAGING NORTHWEST

An Alliance of TRA Medical Imaging and MultiCare Health System

PUYALLUP IMAGING CENTER

222 15th Avenue SE | Puyallup, WA 98372

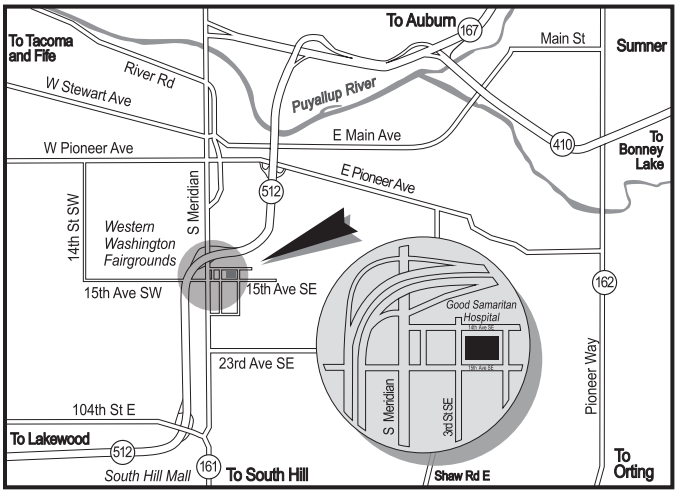
SERVICES AT THIS LOCATION: MRI, CT, Ultrasound, X-ray, DEXA (Bone Density Scan), Mammography, Stereotactic Breast Biopsy, Breast MRI, Guided Biopsy, Fluoroscopy, Creatinine Lab Services; and IV Hydration for low GFR patients requiring CT IV contrast imaging



GOOD SAMARITAN MEDICAL BUILDING

1450 5th St. SE, Suite 4600 | Puyallup, WA 98372

SERVICES AT THIS LOCATION: X-ray



Patient's Appt. Date: _____

Time: _____

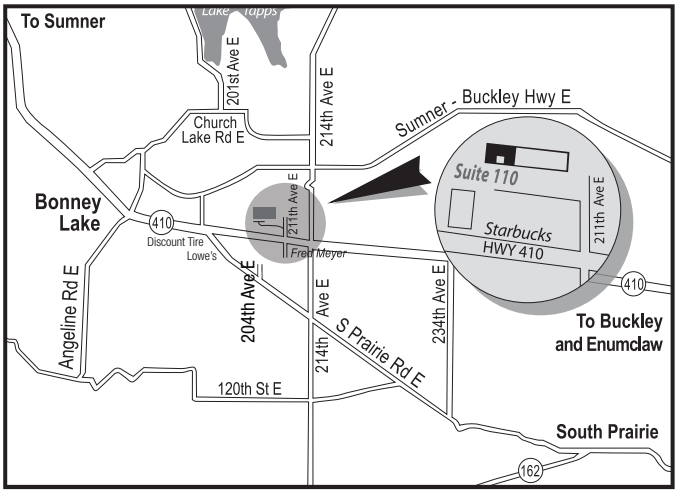
Scheduling and Information: (253) 841-4353

Scheduling Fax: (253) 446-3973

BONNEY LAKE IMAGING CENTER

21110 SR 410 East, Suite 110 | Bonney Lake, WA 98391

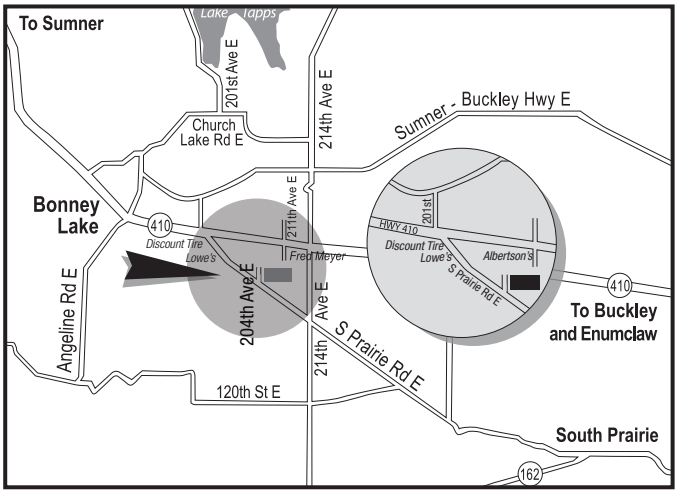
SERVICES AT THIS LOCATION: MRI, CT, Ultrasound, Mammography, DEXA (Bone Density Scan), and Creatinine Lab Services **(NO X-RAY AT THIS LOCATION)**



BONNEY LAKE MEDICAL BUILDING

10004 204th Avenue E. Suite 2600 | Bonney Lake, WA 98391

SERVICES AT THIS LOCATION: X-ray



SUNRISE IMAGING CENTER

11212 Sunrise Blvd. E, Suite 200 | Puyallup, WA 98374

SERVICES AT THIS LOCATION: MRI, CT, Ultrasound, X-ray, Digital Mammography, DEXA (Bone Density Scan), and Creatinine Lab Services