

RADIOLOGY REFERRAL FORM - SPECIALTY

Appointment

Date: _____ Time: _____ Call patient to schedule Patient will call to schedule

Patient Information

Date: _____ Referring Provider: _____

Patient Name: _____ D.OB.: _____

Phone: _____ Interpreter Needed (language): _____

Height: _____ Weight: _____ Pregnant: Yes No Allergies: _____

Clinic History (signs and symptoms REQUIRED)

Signs/Symptoms: _____

Duration: _____ Area: _____

Cause (Hx, Trauma, etc.): _____

Is this due to an injury? Yes No If yes, specify: MVA L&I DOI: _____

Prior Exams

Date: _____ Facility Location: _____

Date: _____ Facility Location: _____

CT SCAN

- No contrast Contrast (at radiologist discretion)
- Head
- Soft Tissue Neck
- Orbits (IAC Post Fossa, temp bones)
- LandmarX
- Maxillofacial
- C-spine
- T-spine
- L-spine
- Chest
- Chest High Resolution
- Cardiac Calcium Score
- Low-dose Lung Screen (patients must meet all criteria below to qualify)
 - Age 55-80 (Medicare only approves up to 77 years of age)
 - Active smoker or quit less or equal to 15 years
 - At least 30 pack-year history (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Abdomen
- Abdomen and Pelvis
- CT Enterography
- CT IVP (urography)
- CT KUB
- CT Urogram
- CTA Head
- CTA Neck
- CTA Abdomen
- CTA Abdomen and Pelvis
- CTA Pelvis
- CTA Runoff
- Extremity _____ L R with joint arthrogram
- Pelvis
- Other _____

Report

Call STAT: (_____) _____ - _____

Fax STAT: (_____) _____ - _____

Fax Routine: (_____) _____ - _____

Additional Report to: _____

Images

- CD ROM
- Web PACS
- PACS
- Deliver to my office
- Send with patient

Insurance Information (Send copy of patient's insurance card when faxing this referral)

Insurance(s): _____

Claim # (if applicable): _____

Pre-Authorization #: _____

MRI EXAM

- No contrast Contrast (at radiologist discretion)
- Patient may have metal in eye (perform x-ray for determination of foreign body if needed)
- Patient has pacemaker
- Patient has implanted device: _____
(make / model / year / facility)
- Sedation for MRI (patient will need a driver)
 - Provider will sedate TRA will sedate
- Brain
- Orbits
- Orbits with Brain
- IAC Screening
- IAC with brain
- Face/Neck
- Soft Tissue Neck
- Pituitary
- Cardiac
- C-spine
- T-spine
- L-spine
- Abdomen: _____
- Pelvis: _____
- Enterography
- MRCP
- MRA: _____
- Extremity with joint arthrogram
 - Ankle L R
 - Elbow L R
 - Hip L R
 - Knee L R
 - Shoulder L R
 - Wrist L R
- Other: _____

INJECTIONS AND INTERVENTIONAL PROCEDURES

Diagnostic and Therapeutic Injection: _____

Interventional Procedure: _____

Patient Consultation, Evaluate, and Treat: _____

Referring Provider Signature (Required for exam) _____

EXAM PREPARATIONS

CT SCAN

- All IV Contrast Exams: no food for four hours prior to scheduled exam. Clear liquid up to appointment time is permitted.
- Abdominal/Pelvic CT Exams: arrive one hour prior to appointed time for exam preparation.

MRI

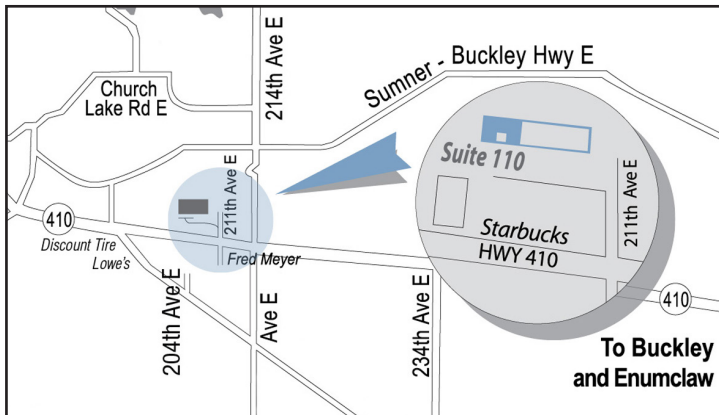
Notify us prior to your appointment if you have the following:

- Pacemaker
- Electronic device or metallic implant
- Brain aneurysm clip
- Heart valve replacement
- Stent
- Metal eye injury

LOCATIONS

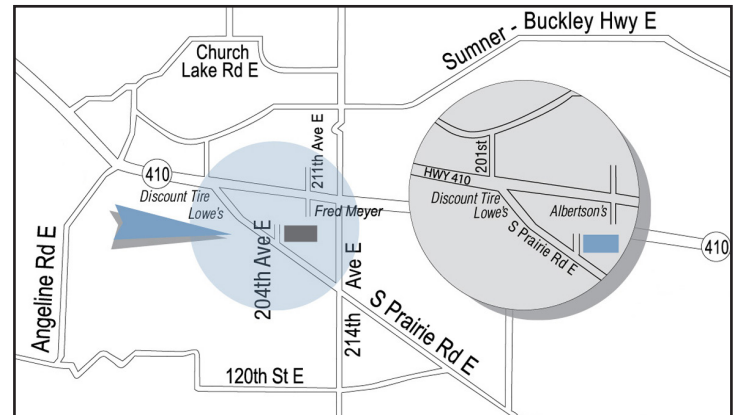
BONNEY LAKE IMAGING CENTER

21110 SR 410 E Ste 110, Bonney Lake WA 98391



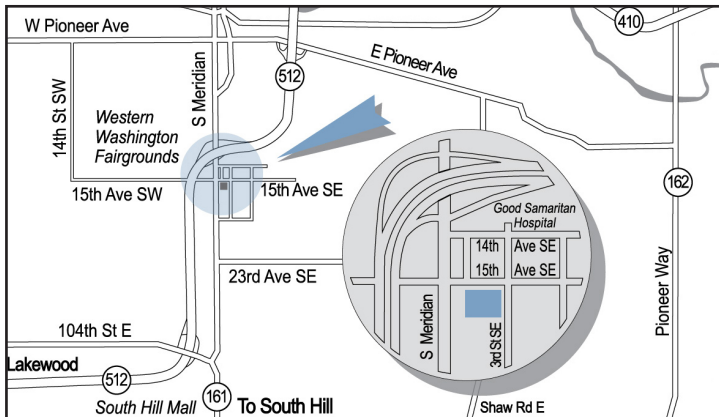
BONNEY LAKE MEDICAL BUILDING

10004 204th Ave E Ste 2600, Bonney Lake WA 98391



PUYALLUP IMAGING CENTER

222 15th Ave SE, Puyallup WA 98372



SUNRISE IMAGING CENTER

11212 Sunrise Blvd Ste 200, Puyallup WA 98374

