MOBILE X-RAY: RADIOLOGY REFERRAL FORM

Phone: **253-680-3620** Fax: **253-680-3621** **dinw.com**

DIAGNOSTIC IMAGING NW
A MULTICARE HEALTH SYSTEM AND TRA MEDICAL IMAGING PARTNERSHIP

Order Date: _____ **Exam Date:** _____

Physician/Ordering Facility

Name: _____
Contact: _____
Address: _____
Phone: _____ Fax: _____

Patient Information

Name: _____
D.OB.: _____ Room Number (if applicable): _____
Address: _____
Phone: _____ Interpreter Needed (language): _____

Responsible Party

Name: _____ Phone: _____
Address: _____

Report

Call Positive: _____ - _____ - _____
Fax: _____ - _____ - _____

Images

❑ CD
❑ Web PACS
❑ PACS
❑ Deliver to my office
❑ Leave with patient

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

Medicare #: _____
Medicaid #: _____
CO/Other Insurance: _____
Policy #: _____

MOBILE X-RAY EXAM

(This patient would find it physically and/or psychologically taxing because of advanced age or physical limitations to receive an x-ray outside this location. This test is medically necessary for the diagnosis and treatment of this patient.)

Head and Neck

❑ Skull Limited (AP and Lateral)
❑ Sinus Limited (Waters)
❑ Sinuses (3 view)
❑ Facial Bones (3 view)
❑ Nasal Bones (3 view)

Chest

❑ Chest (AP)
❑ Chest (AP and Lateral)
❑ Ribs Unilat w/CXR
❍ L ❍ R
❑ Ribs Bilat w/CXR
❑ Sternum (2 view)

Upper Extremity

❑ Scapula (2 view)
❍ L ❍ R
❑ Shoulder (2 view)
❍ L ❍ R
❑ Clavicle (2 view)
❍ L ❍ R
❑ Forearm (2 view)
❍ L ❍ R
❑ Elbow (3 view)
❍ L ❍ R
❑ Wrist (3 view)
❍ L ❍ R
❑ Hand (3 view)
❍ L ❍ R
❑ Humerus (2 view)
❍ L ❍ R
❑ Finger (3 view)
❍ L ❍ R

Lower Extremity

❑ Hip (2 view)
❍ L ❍ R
❑ Hip Bilat (4 view)
❍ L ❍ R
❑ Femur (2 view)
❍ L ❍ R
❑ Knee (AP and lateral)
❍ L ❍ R
❑ Knee (3 view)
❍ L ❍ R
❑ Tibia/Fibula (2 view)
❍ L ❍ R
❑ Ankle (3 view)
❍ L ❍ R
❑ Foot (3 view)
❍ L ❍ R
❑ Heel/Calcaneus (2 view)
❍ L ❍ R

Spine

❑ Cervical (2-3 view)
❑ Thoracic (2 view)
❑ Lumbar (3 view)
❑ Sacrum/Coccyx (2 view)
❑ Pelvis (1 view)

Gastro-Urological

❑ Abdomen/KUB (1 view)
❑ Abdomen (2 view)

Other

❑ _____

Reasons for Mobile Services

Symptoms/Brief History/Diagnosis: _____
Has this patient tested positive or have a pending test for COVID-19? ❑ Yes ❑ No

Reasons for Portability (check all that apply):

❒ Bedridden due to illness
❒ Chronic disease
❒ Contact isolation
❒ Continuous IV
❒ Dementia
❒ Fall risk/status post fall
❒ Injury
❒ Medication: strict requirement of administration
❒ Medication: adverse side effects
❒ Mentally challenged
❒ Pneumonia
❒ Oxygen dependent
❒ Senile/confused
❒ Unresponsive
❒ Weakness/frail
❒ Wheelchair bound

ICD Diagnosis Codes: _____ _____ _____ _____ _____

Referring Provider Signature (Required for exam) ⟶ _____