RADIOLOGY REFERRAL FORM - COMMON

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

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: _____

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 #: _____

X-RAY

❑ Orbits for MRI clearance
❑ Sinus Limited (Waters)
❑ Sinus Complete
❑ Cervical Spine
❑ Shoulder L R Bi-lat
❑ Ribs L R Bi-lat
❑ Chest
❑ Chest Decub L R Bi-lat
❑ Thoracic Spine
❑ Abdomen
❑ Acute Abdomen Series
❑ Humerous L R Bi-lat
❑ Elbow L R Bi-lat
❑ Lumbar Spine
❑ Hip L R Bi-lat
❑ Bilateral Hips & Pelvis
❑ Ped Pelvis
❑ Pelvis only
❑ Pelvis w/Lateral Hip
❑ SI Joints
❑ Forearm L R Bi-lat
❑ Wrist L R Bi-lat
❑ Hand L R Bi-lat
❑ Finger L R Bi-lat
Specify digit: _____
❑ Sacrum/Coccyx
❑ Scoliosis
❑ Femur L R Bi-lat
❑ Knee L R Bi-lat
❑ Tib/Fib L R Bi-lat
❑ Ankle L R Bi-lat
❑ Calcaneous (heel) L R Bi-lat
❑ Foot L R Bi-lat
❑ Toe L R Bi-lat
Specify digit: _____
❑ Other: _____

FLUOROSCOPY

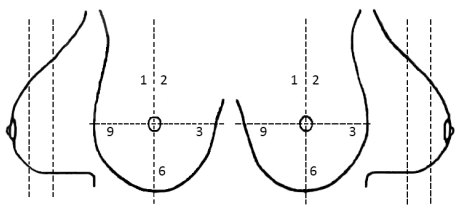
❑ HSG
❑ Esophagram
❑ Upper GI Series
❑ Cystogram
❑ Other: _____

BONE DENSITOMETRY (DEXA)

❑ Pediatric DEXA
❑ Spine and Femur
❑ Vertebral Fracture Assessment
❑ Other: _____

BREAST IMAGING

Date of last mammogram: _____
❑ Breast Ultrasound: R/L/Bilat
❑ Breast MRI with/without contrast
❑ Breast MRI without contrast
❑ Cyst Aspiration
❑ Diagnostic Mammography (symptomatic)
❍ Uni ❍ Bi-lat
❑ Galactogram: R/L
❑ Screening Mammography (asymptomatic)
❍ Uni ❍ Bi-lat
❑ Stereotactic Biopsy: R/L
❑ US-Guided Biopsy: R/L
❑ Wire Localization: R/L



Document Palp Abn: _____
O'clock: _____ N+: _____

ULTRASOUND

❑ Thyroid/Neck
❑ Abdomen- Complete
❍ Elastography
❑ Abdomen- Limited: _____
❑ Renal
❑ AAA Screen *(Medicare only- once a lifetime)*
❑ AAA follow-up *(retroperitoneal, limited)*
❑ Appendix
❑ Pelvic *(transabdominal and/or transvaginal as needed for diagnostic visualization)*
❑ Hysterosonogram
❑ Bladder Post-Void Residual
❑ Testicular/Scrotal
❑ Hernia, location: _____
❑ Extremity non-vascular: _____
❑ OB LMP/EDD: _____
❍ Multiple ❍ High Risk
❍ < 14 weeks complete *(TV as needed for visualization)*
❍ > 14 weeks complete *(TV as needed for visualization)*
❍ Follow-up EFW
❍ Umbilical Cord Doppler if indicated
❑ OB Biophysical Profile
❑ OB Limited (AFI, Position, previous anatomy not seen)
❑ Infant
❍ Head ❍ Hip ❍ Spine ❍ Pyloris
❑ Carotid Duplex Doppler
❑ Renal Artery Duplex
❑ Duplex Upper Extremity Veins: Bilat/R/L
❑ Duplex Lower Extremity: Arteries/Veins/R/L/Bilat
❑ Duplex Lower Extremity Varicose Veins: R/L/Bilat
❑ Duplex Doppler Vascular Other: _____
❑ Other: _____

Referring Provider Signature (Required for exam) → _____

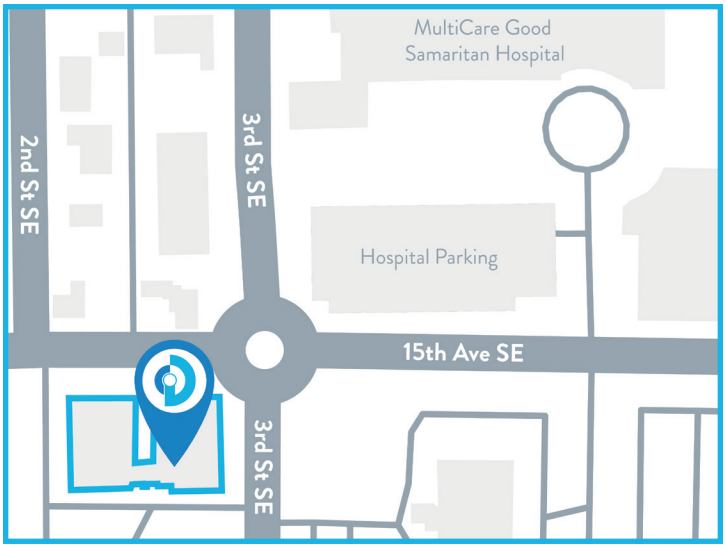
LOCATIONS

BONNEY LAKE IMAGING CENTER

21110 SR 410 E Ste 110, Bonney Lake WA 98391

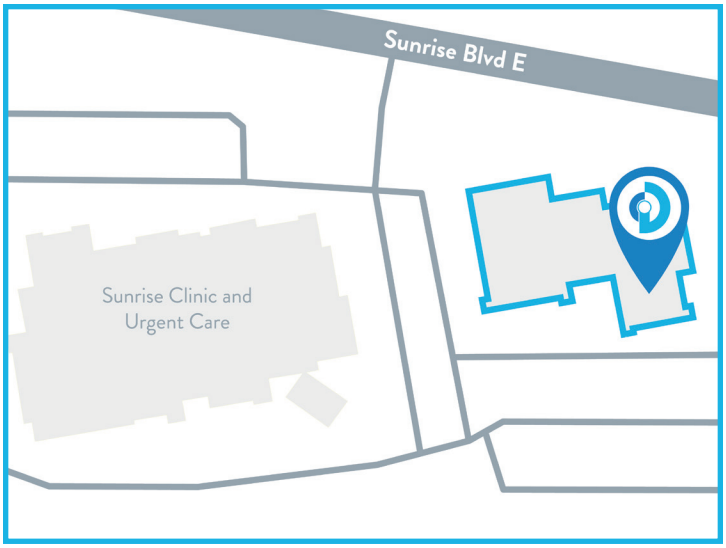
PUYALLUP IMAGING CENTER

222 15th Ave SE, Puyallup WA 98372



SUNRISE IMAGING CENTER

11212 Sunrise Blvd Ste 200, Puyallup WA 98374



EXAM PREPARATIONS

BONE DENSITOMETRY (DEXA)

- ❒ No preparation.

FLUOROSCOPY

- ❒ **HSG:** Exam must be performed within 3-5 days of the last day of your menstrual cycle; abstain from sexual intercourse starting the first day of your menstrual cycle until otherwise directed by your physician; if you think you might be pregnant, it is important that you tell us before your exam.

ULTRASOUND - US

- ❒ **Abdominal Exam:** *Night before:* Fat-free dinner; non-fat liquids permitted until *6 hours prior to exam,* then nothing by mouth.
- ❒ **Kidney, Renal, and Renal Artery:** *One hour prior to your exam*: Empty your bladder; drink 16 ounces of water; do not empty your bladder.

ULTRASOUND - OB

- ❒ **Less than 14 weeks:** *One hour prior to your exam*: Empty your bladder; drink 32 ounces of water; do not empty your bladder.
- ❒ **More than 14 weeks:** Do not empty your bladder for 1 hour prior to your appointment.
- ❒ **Pelvic and/or Trans Vaginal:** *One hour prior to your exam*: Empty your bladder; drink 32 ounces of water; do not empty your bladder.

BREAST IMAGING

- ❒ Do not wear powder, deodorant, or lotion to exam.

X-RAY

- ❒ No preparation.

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