RADIOLOGY REFERRAL FORM - SPECIALTY

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: _____

Creatinine/GFR: _____ / _____ Date Drawn: _____

❑ I authorize on-site creatinine/BUN (lab) testing if needed.

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: _____

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 #: _____

Prior Exams

Date Facility Location

_____ _____

CT SCAN

❑ **No contrast** ❑ **Contrast (at radiologist discretion)**

❑ Head
❑ Soft Tissue Neck
❑ Orbits (IAC Post Fossa, temp bones)
❑ LandmarX / Steath
❑ Maxillofacial / Sinus
❑ 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 50-80 (Medicare only approves up to 77 years of age)
  ❍ Active smoker or quit less or equal to 15 years
  ❍ At least 20 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 (Urogram)
❑ CT KUB
❑ CTA Head
❑ CTA Neck
❑ CTA Abdomen
❑ CTA Abdomen and Pelvis
❑ CTA Pelvis
❑ CTA Runoff
❑ Extremity _____ L R ❍ with joint arthrogram
❑ Pelvis
❑ Other _____

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)
❑ Brain
❑ Orbits
❑ Orbits with Brain
❑ IAC Screening
❑ IAC with brain
❑ Face/Neck
❑ Soft Tissue Neck
❑ Pituitary
❑ 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) → _____

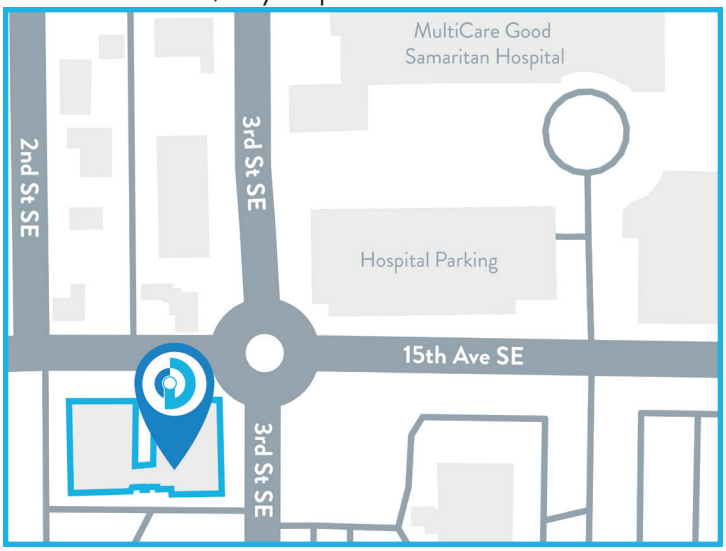
LOCATIONS

BONNEY LAKE IMAGING CENTER

21110 SR 410 E Ste 110, Bonney Lake WA 98391

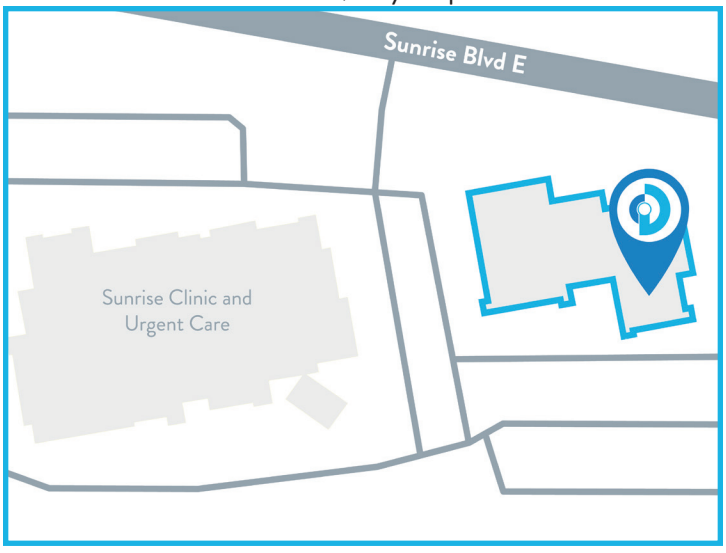
PUYALLUP IMAGING CENTER

222 15th Ave SE, Puyallup WA 98372



SUNRISE IMAGING CENTER

11212 Sunrise Blvd Ste 200, Puyallup WA 98374



EXAM PREPARATIONS

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

Phone: **253-841-4353**

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