Hospital Imaging Requisition Order

ROCKWOOD HEALTH SYSTEM®
Deaconess Hospital | Valley Hospital

☐ **DEACONESS HOSPITAL**: Scheduling: 509.473.7777 | Fax: 509.473.7511 | Radiologist Contact: 509.822.4400
☐ **VALLEY HOSPITAL**: Scheduling: 509.473.5483 | Fax: 509.473.5490 | Radiologist Contact: 509.822.4400
☐ **DEACONESS NORTH EMERGENCY CENTER**: Scheduling: 509.473.7777 | Fax: 509.473.7511 | Radiologist Contact: 509.822.4400

☐ **Call patient to schedule** ☐ **Patient will call** ☐ **Confirm that order has been received**

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____ ☐ Male ☐ Female
Last *First* *MI*

Best Patient Phone: _____ ☐Cell ☐Home ☐Work

Primary Insurance: _____ ID#: _____ GRP: _____

Subscriber Name: _____

Secondary Insurance: _____ ID#: _____ GRP: _____

Primary Care Provider: _____ Referring Provider: _____

EXAM REQUESTED / REASON FOR EXAM / SYMPTOMS / SPECIFIC AREA OF INTEREST

CPT Code: _____ **ICD-10 Code:** _____

Is authorization required? ☐ Yes ☐ No If yes, auth #: _____ Date range: _____

Diagnosis/reason for exam: _____

_____

☐ X-Ray _____

☐ General Ultrasound _____ ☐ Vascular Ultrasound _____

☐ Screening Mammogram ☐ Diagnostic Mammogram *(Deaconess only)* ☐Stereo biopsy/localization *(Deaconess only)* _____

☐ CT _____

☐ PET CT _____

☐ MRI ☐DTI ☐Perfusion _____ *Deaconess only:* ☐ 1.5T ☐ 3T

☐ ECHO *(available at both hospitals and ACI)* _____

☐ Nuclear Medicine _____

☐ EEG _____

☐ Gamma Knife _____

☐ Interventional Radiology _____

☐ Barium Studies _____

☐ Arthrogram _____ ☐ Myelogram ☐ Cervical ☐ Thoracic ☐ Lumbar

RECENT LAB WORK

Answer questions in this box for CT and/or MRI with contrast:

IV Contrast ☐ Yes ☐ No ☐ PRN

Previous Contrast Reaction? ☐ Yes ☐ No

A creatinine within 30 days is required if patient has:

Diabetes ☐ Yes ☐ No
Renal Disease ☐ Yes ☐ No
Age > 60 ☐ Yes ☐ No

Creatinine: _____ Date: _____

BUN: _____ Date: _____

Does patient have: Aneurysm clip? Metal in eyes: Pacemaker?
Other implanted electronic devices? ☐ Yes ☐ No
Specify: _____

Is patient claustrophobic? ☐ Yes ☐ No

REPORT

☐ **Routine** ☐ Call Report # _____ ☐ Call Report/Patient Wait

☐ **STAT** ☐ Fax Report # _____ ☐ Other _____

Name: _____ Phone: _____ Fax: _____

Date of next appointment with referring doctor: _____

Physician Signature: _____ **Date:** _____ **Time:** _____

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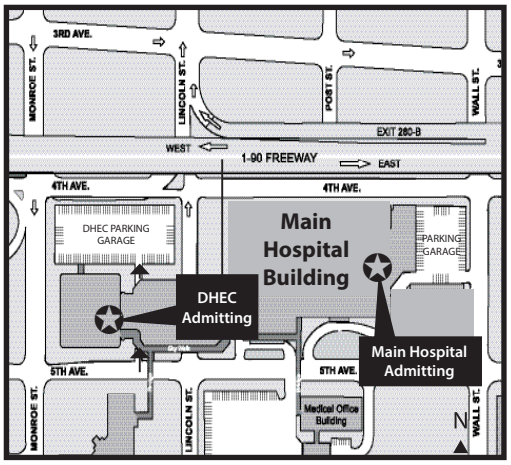
Diagnostic Imaging Locations



Deaconess Hospital

800 W. Fifth Avenue
Spokane, WA 99204
Imaging: 509.473.7777

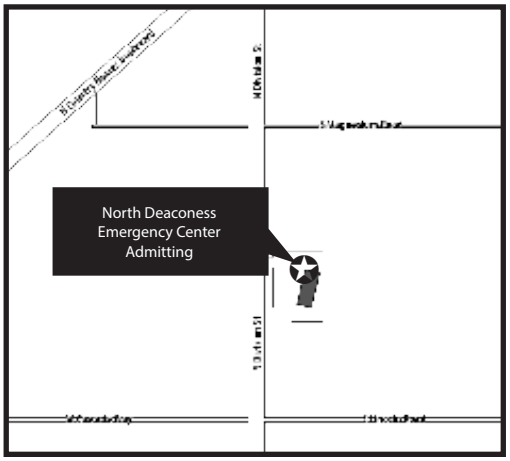
FOR MRI, ADVANCED CARDIAC IMAGING & GAMMA KNIFE:
Please park in the DHEC garage and check-in with Admitting on the 2nd floor (main level) of DHEC at the end of the hall to the left.

FOR CT, X-RAY, MAMMOGRAM, ULTRASOUND, INTERVENTIONAL RADIOLOGY, EEG & NUCLEAR MEDICINE :

Please park in the garage attached to the main hospital and check-in with Admitting on the 1st floor near the entrance from the garage.

You are also welcome to park at the meters along the street.

Parking in either garage or Deaconess Circle Drive valet is $3.

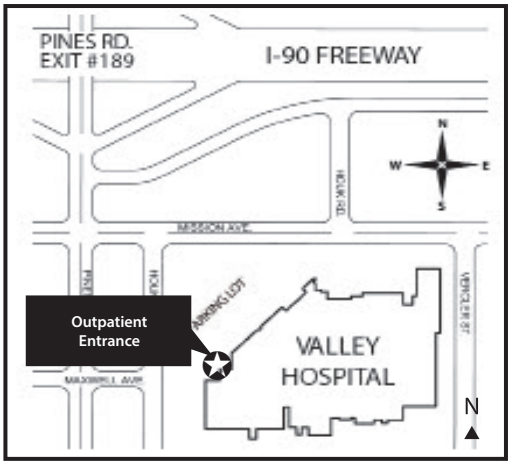


Deaconess North Emergency Center

8202 N. Division St.
Spokane, WA 99208
Imaging: 509.473.7777

FOR ALL IMAGING PROCEDURES:
Please park in the lot in front of the hospital and use the Outpatient Services/Health entrance on the west side of the building.

Parking is free in the Deaconess North Emergency Center lot.



Valley Hospital

12606 E. Mission Avenue
Spokane Valley, WA 99216
Imaging: 509.473.5483

FOR ALL IMAGING PROCEDURES:
Please park in the lot in front of the hospital and use the Outpatient Services/Health and Education Center entrance on the west side of the building.

Parking is free in the Valley Hospital lot.