REQUIRED

Priority
☐ **STAT**
☐ Routine
☐ Call Critical Result to:
#_____

Height _____
Weight _____

Diagnosis:_____
Signs/Symptoms:_____
_____
Diagnosis Codes:_____
Insurance Name:_____ **Authorization #:**_____ **Expires:**_____
☐ **No Authorization required, Determined by (Name):**_____

EXAM REQUESTED — BREAST IMAGING ✳✳✳USE SEPARATE REFERRAL FORM (DI17167)✳✳✳

X-ray No appointment required for general x-ray, multiple x-ray locations (see reverse). Fluoroscopy and arthrograms requires appointments.

☐ Chest 2v ☐ Abdomen Acute ☐ Shoulder 3v R / L ☐ Knee 3v R / L ☐ L-Spine Complete ☐ C-Spine Complete
☐ Chest 1v ☐ Abdomen 2v ☐ Wrist 3v R / L ☐ Pelvis ☐ L-Spine Limited ☐ C-Spine Limited
☐ Ribs R / L ☐ Abdomen 1v (KUB) ☐ Hand 3v R / L ☐ Hip w/ Pelvis R / L

Other (specify area):_____ ☐ Left ☐ Right

Fluoroscopy *(Appt. Required)* ☐ Esophagram ☐ Upper GI (Esophagus, Stomach, Duodenum) ☐ Small Bowel (follow through)
☐ Air Contrast Barium Enema ☐ Water soluble Contrast Enema ***Other (specify)***:_____

Arthrogram *(Appt. Required)* Joint: _____ ☐ MRI to follow ☐ CT to follow

Bone Density Date of Last Exam:_____ ☐ Central (spine/femur) to evaluate fracture risk.
☐ Peripheral (forearm); primary PTH, patients above 350# table limit, bilateral hip/spine hardware

CT* (Requirements below) ✳**Medication List required w/ Contrast**✳

☐ Brain ☐ Orbits ☐ Facial Bones ☐ Sinuses
☐ Neck, Soft Tissue ☐ Chest ☐ Abdomen ☐ Pelvis
☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine
Other (specify):_____

Specify Contrast for exam: ☐ As medically indicated
☐ With IV Contrast ☐ Without IV contrast
☐ With Oral Contrast ☐ No Oral Contrast ☐ Rectal Contrast

CT Angio (with IV contrast) ☐ Head ☐ Neck ☐ Chest
☐ Abdomen & Pelvis ☐ Renal ☐ Bilateral Lower Ext.
Other (specify):_____

CT Guided Biopsy: _____

MRI* (Requirements below) ✳**Medication List required w/ Contrast**✳

☐ **Orbit X-rays** (if history of eye injury with metal)
☐ Brain ☐ IAC ☐ Soft Tissue Neck
☐ Chest ☐ Abdomen ☐ Pelvis ☐ Hip L / R
☐Cervical Spine ☐Thoracic Spine ☐ Lumbar Spine ☐ Sacrum

Extremity: ☐ **Left** ☐ **Right**
☐ Shoulder ☐ Elbow ☐ Wrist ☐ Knee ☐ Ankle ☐ Foot
Other (specify):_____

Specify IV Contrast for above exam: ☐ As medically indicated
☐ With and without IV contrast ☐ No IV contrast

MRA: ☐ Head ☐ Neck ☐ Chest ☐ Abdomen and Pelvis
☐ Bilateral Lower Ext. ***Other (specify):***_____

***CT & MRI Requirements** **Patients needing a contrast** study **with history** of kidney disease, diabetes, chemotherapy in the last week, recent serious illness or over age 60, must have a serum creatinine test within 30 days of appointment:
☐ **Serum Creatinine (Lab Order)** or **Recent Lab Results:** Serum Creatinine:_____ Date:_____

Patients on Metformin: >> ☐ **Metformin Hold (Required)** first 48 hours **post** CT contrast injection.
Medication List Attached (w/ Contrast)**:** ☐ Y ☐ N Diabetic: ☐ Y ☐ N >> Diabetic Medication changes discussed: ☐ Y ☐ N
Allergy to contrast: ☐ Y ☐ N Pre medication instructions given: ☐ Y ☐ N
Heart Surgery: ☐ Y ☐ N

Nuclear Medicine **Bone Scan -** ☐ Total Body ☐ Limited - specify area:_____ with: ☐ SPECT ☐ 3-phase
Other nuclear medicine scan (specify): _____

Ultrasound

Abdomen and Thyroid
☐ Abdomen Complete
☐ Abdomen Limited, Single Organ
☐ Aorta
☐ Renal
☐ Renal w/ Bladder
☐ Thyroid
☐ Thyroid with FNA
☐ Vascular (specify):_____
Other (specify):_____

Pelvis
☐ Pelvic w/ Transvaginal LMP_____
☐ Scrotal with Doppler
Other (specify):_____

OB - LMP_____
☐ OB < 14 Wks. w/ Transvaginal
☐ OB > 14 Wks. w/ Transvaginal PRN
☐ OB Ltd
☐ OB F/U
☐ Transvaginal (Cervix,low placenta, etc.)
Other (specify):_____

Vascular* ******(exam details on back of form)**
☐ Carotid Duplex
Arterial (Physiologic testing): ☐Lower Ext ☐Upper Ext
☐ ABI Complete ☐ ABI Limited
☐ w/exercise ☐ w/exercise
Arterial Duplex: ☐Lower Ext ☐ Upper Ext
☐ Bilateral Unilateral: ☐ Right ☐ Left
☐ with ABI ☐ with exercise ABI
Venous Duplex: ☐ Lower Ext ☐ Upper Ext
☐ Bilat ☐ R ☐ L
☐ Renal Arterial Duplex
Other (specify):_____

Provider Signature: _____ _____ Provider Name:_____
(First Initial / Last Name / Title) Date / Time **(Please Print)**

OLYMPIC MEDICAL IMAGING CENTER
939 Caroline St.
Port Angeles, WA 98362

Diagnostic Imaging Orders
DI21183 8/19/2015

Fax this order to: (360) 565-9001
Scheduling: Call 565-9003

REQUIRED

Patient Name:_____
DOB:_____ **Phone #:**_____
CC:_____
Appointment Date/Time:_____

Patient Instructions

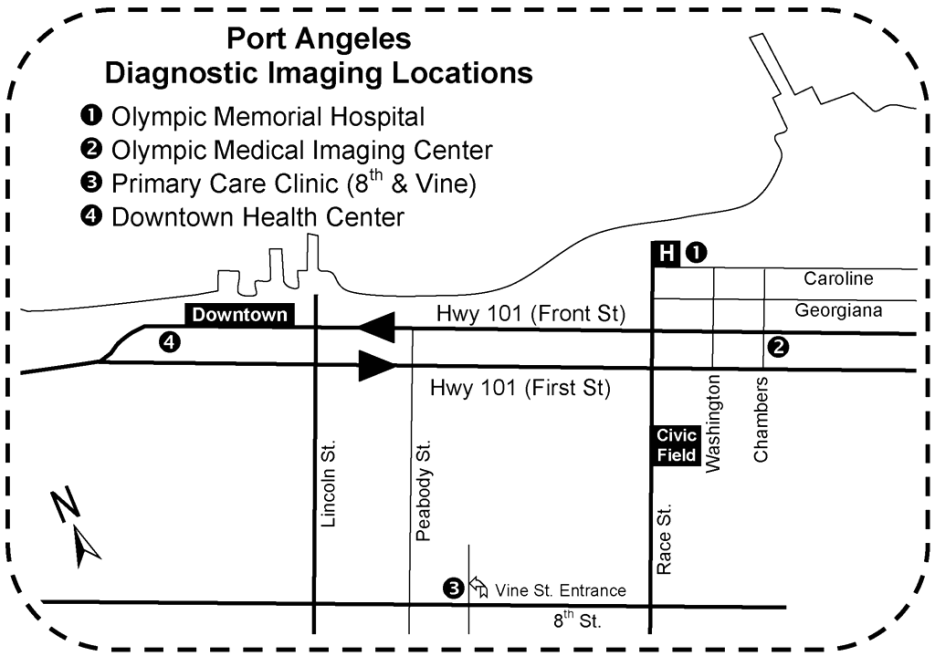
Thank you for choosing Olympic Medical Center for your diagnostic imaging needs.

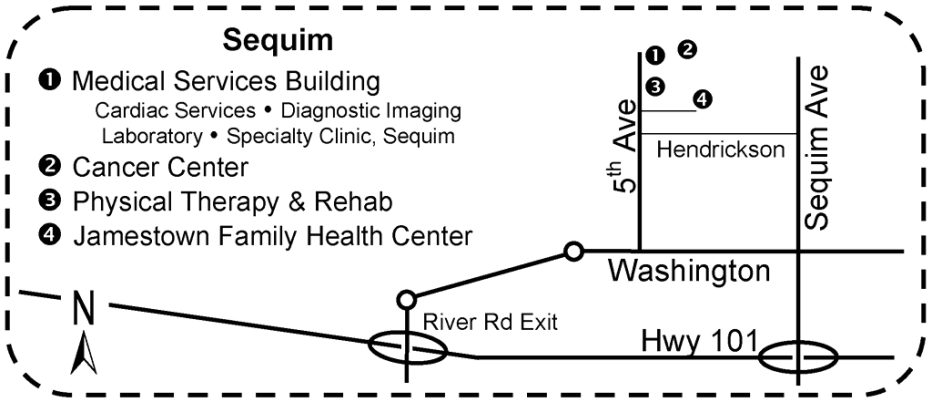
- **Please, no cell phones with you during the exam.**
- **During OB Ultrasound Exams: Two guests will be permitted with the patient. The guests must be 12 years of age or older.**
- **Scheduled patients accompanied by children under the age of 12 and without another adult present, will need to reschedule their appointment.**

DETAILED INFORMATION FOR VASCULAR ULTRASOUND EXAMS

*Peripheral Arterial Evaluations	** Peripheral Venous Evaluations
Lower Extremity Arterial includes: Physiologic testing (ABI's and/or treadmill exercise testing). Duplex – Lower Extremity ultrasound for stenosis/atherosclerosis	Lower Extremity Venous with duplex: DVT - femoro-popliteal, tibio-peroneal & great saphenous veins. Pre-Vein Ablation/Closure Evaluation for patients with planned therapeutic intervention
Upper Extremity Arterial includes: Physiologic Testing or Duplex as needed	Upper Extremity Venous with duplex: Extremity veins including response to compression & other maneuvers

Two convenient general X-ray locations in Port Angeles available (in addition to the hospital)





Port Angeles

- ❑ Olympic Memorial Hospital
  939 Caroline St.
- ❑ Olympic Medical Imaging Center
  1102 E Front St.
  Mammography / Bone Density only
- ❑ Downtown Health Clinic
  240 W. Front St., Suite
  X-Ray Only, All walk-in's welcome
- ❑ OMP 8th Street Radiology
  433 E. 8th St.
  Use Vine Street Entrance
  X-Ray Only, All walk-in's welcome

Sequim

- ❑ Medical Services Building
  840 N. 5th Ave.,
  Suite 1100
- ❑ Jamestown Family Health Center
  808 N. 5th Ave.
  X-Ray Only