WhidbeyHealth Medical Center
101 N. Main Street, Coupeville WA, 98239
360.678.5151 360.321.5151
www.whidbeyhealth.org

DIAGNOSTIC IMAGING REQUISITION

Scheduling Line: 360-678-7607 M-F 8am-5pm, Sat 8am-4pm) Fax: 360 678-7652

Date and Time of Exam: _____ MRN: _____

PATIENT DATA

LAST NAME FIRST NAME MI

DOB TELEPHONE

PRIORITY OF STUDY

☐ STAT ☐ ROUTINE

Call Back Phone #:_____

PROCEDURE INFORMATION

Insurance:

Authorization #:

Date of Injury/Onset:

Diagnosis/Signs/Symptoms to indicate reason for the procedure: _____

_____

CT

☐ Head ☐ Abd/ Pel ☐ L-Spine
☐ C-Spine ☐ KUB ☐ T-Spine
☐ Chest ☐ IVP ☐ Ext:_____
☐ PE Chest ☐ Other:_____

IV CONTRAST: ☐ WITH ☐ WITHOUT

ORAL CONTRAST: ☐ WITH ☐ WITHOUT

MRI

☐ Brain ☐ Knee ☐ Rt ☐ Lt ☐ Bilat
☐ C-Spine ☐ Shoulder ☐ Rt ☐ Lt ☐ Bilat
☐ T-Spine ☐ MRA:_____
☐ L-Spine ☐ Other:_____

IV CONTRAST: ☐ WITH/WITHOUT ☐ WITHOUT

If a Creatinine, Beta or Urine HcG is needed please order it below and fax an order to WH lab: (360) 678-7631.

Creatinine: ☐ **Y** ☐ **N** **Beta or Urine HcG:** ☐ **Y** ☐ **N**

Creatinine Required (within 30 days prior to exam) for CT and MRI IV contrast if:

Result:_____ **Date Drawn:**_____

NUCLEAR MEDICINE

☐ Bone Scan_____
☐ Thyroid Scan and Uptake
☐ Cholescintogram (HIDA)
☐ Ventilation/Perfusion Scan (VQ)
*Order for Chest X-ray….if not done with 12 hours

☐ **ECHO**
- ☐ Perform agitated saline study (Bubble Study) if indicated
- ☐ May use Echo contrast agent (Definity) if indicated

☐ **FLUORO**
- ☐ Modified Barium Swallow (w/Speech)
- ☐ UGI
- ☐ Esophagram/Barium Swallow

STRESS TESTS

☐ NM MPS – Myocardial Perfusion Scan
☐ Stress Echo
☐ Exercise Treadmill Test (Plain – ETT)
- ☐ Exercise – Modified or Bruce (Circle One)
- ☐ Persantine (0.56mg/kg)_____mg (NTE 60 mg)
- ☐ Adenosine (0.84 mg/kg)_____mg
- ☐ Lexiscan

XRAY

☐ XRAY:_____ ☐ Rt ☐ Lt ☐ Bilat

Provider Signature: _____ **Date/Time:** _____

Printed Name of Ordering Provider: _____

* R D I R *

PATIENT ID LABEL