

SEATTLE RADIOLOGY

Scheduling: 206.292.7734
 Fax: 206.292.6371 EHR: 206.292.7744 www.searad.com

SATURDAY APPOINTMENTS AVAILABLE

PATIENT INFORMATION:

Patient Name: _____ DOB: ____ / ____ / ____
 Phone: Cell/Other _____ Home _____
 Insurance Company: _____
 Insurance ID: _____
 Auth # _____ Valid from: _____ to: _____

HISTORY / SYMPTOMS / DIAGNOSIS (RULE-OUT TO INCLUDE HISTORY):

ICD-10 Code: _____

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| <h3>CT SCAN</h3> <p>Contrast options: <input type="checkbox"/> w/ <input type="checkbox"/> w/o <input type="checkbox"/> wwo <input type="checkbox"/> prn</p> <p><input type="checkbox"/> Head <input type="checkbox"/> Temporal Bone <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Enterography</p> <p style="text-align: center;">Specify Level</p> <p><input type="checkbox"/> C-Spine: _____ <input type="checkbox"/> T-Spine: _____ <input type="checkbox"/> L-Spine: _____ <input type="checkbox"/> Extremity Upper _____ L / R <input type="checkbox"/> Extremity Lower _____ L / R</p> <p><input type="checkbox"/> Wrist/Hand L / R <input type="checkbox"/> Ankles/Foot L / R <input type="checkbox"/> Cardiac/Calcium Score</p> <p><input type="checkbox"/> Other: _____</p> <h3>CT ANGIO</h3> <p><input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Bilat Ext Runoffs <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Coronary <input type="checkbox"/> Renal</p> | <h3>MRI SCAN</h3> <p>Contrast options: <input type="checkbox"/> w/ <input type="checkbox"/> w/o <input type="checkbox"/> wwo <input type="checkbox"/> prn</p> <p><input type="checkbox"/> Oral Sedation Needed? <input type="checkbox"/> Brain <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen/Liver Studies <input type="checkbox"/> SI Joints <input type="checkbox"/> Pelvis <input type="checkbox"/> Enterography <input type="checkbox"/> Prostate <input type="checkbox"/> Rectal</p> <p><input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Ankles/Foot L / R <input type="checkbox"/> Hand/Finger L / R <input type="checkbox"/> Extremity Upper: _____ L / R <input type="checkbox"/> Extremity Lower: _____ L / R</p> <h3>MRI ANGIO</h3> <p>Contrast options: <input type="checkbox"/> w/ <input type="checkbox"/> w/o <input type="checkbox"/> wwo <input type="checkbox"/> prn</p> <p><input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Aortic Arch/Thoracic <input type="checkbox"/> Abdomen <input type="checkbox"/> Bilat Ext Runoffs</p> <h3>BREAST IMAGING</h3> <p><input type="checkbox"/> MRI Breast <input type="checkbox"/> MRI Breast Biopsy L / R <input type="checkbox"/> Abbreviated Breast MRI</p> | <h3>ULTRASOUND</h3> <p>Doppler as clinically indicated, OR <input type="checkbox"/> No Doppler Transvaginal as clinically indicated, OR <input type="checkbox"/> No Transvaginal</p> <p><input type="checkbox"/> Thyroid <input type="checkbox"/> Fine Needle Aspiration Site: _____ <input type="checkbox"/> Carotid Duplex <input type="checkbox"/> Aorta <input type="checkbox"/> Soft Tissue Body Part: _____ <input type="checkbox"/> Low Ext Venous Duplex <input type="checkbox"/> Lower Ext Arterial <input type="checkbox"/> Duplex Abdomen Organ: _____ <input type="checkbox"/> Transplant: _____ <input type="checkbox"/> Renal <input type="checkbox"/> Pelvic <input type="checkbox"/> Pelvic w/ Transvaginal <input type="checkbox"/> Scrotal <input type="checkbox"/> Scrotal w/ Doppler <input type="checkbox"/> Inguinal Hernia <input type="checkbox"/> Ankle/Brachial Indices <input type="checkbox"/> Obstetric EDC or LMP: _____ Week: _____ <input type="checkbox"/> Other: _____</p> <h3>BREAST IMAGING</h3> <p><input type="checkbox"/> Ultrasound Breast L / R <input type="checkbox"/> Ultrasound Breast Biopsy L / R</p> |
|---|---|---|

Date: _____

REFERRING PROVIDER INFORMATION:

Provider Name: _____
 Provider Signature: _____
 Office Contact Name: _____
 Phone: _____
 After Hours Phone: _____

- Routine Report: Faxed within 24 hours
 ASAP Report: Faxed within 2 hours
 STAT Report: Immediate Report Faxed for Critical Results
- Fax number: _____
 Call Report: _____ phone number

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| <h3>PET-CT</h3> <p><input type="checkbox"/> F18 NaF Oncologic Bone Scan <input type="checkbox"/> FDG Brain <input type="checkbox"/> FDG Whole body <input type="checkbox"/> Skull Base to Mid-Thigh <input type="checkbox"/> FDG <input type="checkbox"/> Axumin <input type="checkbox"/> Netspot <input type="checkbox"/> Additional contrast enhanced CT _____ <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis</p> <h3>ARTHROGRAM</h3> <p><input type="checkbox"/> Arthrogram/CT <input type="checkbox"/> Arthrogram/MRI</p> <p><input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> Other: _____ L / R</p> <h3>ASPIRATIONS</h3> <p><input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Knee L / R</p> <h3>PUNCTURES</h3> <p><input type="checkbox"/> Lumbar Puncture Opening Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-10 Code: _____ Labs: Please fax.</p> <h3>MYELOGRAM</h3> <p><input type="checkbox"/> Myelogram w/CT <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar</p> | <h3>SPINE INJECTIONS</h3> <p>Treatments: <input type="checkbox"/> 1x <input type="checkbox"/> Up to 3x</p> <p><input type="checkbox"/> Epidural C-Spine <input type="checkbox"/> Epidural L-Spine <input type="checkbox"/> Nerve Root Block/ Transforaminal Lumbar Side & Level: _____ <input type="checkbox"/> Facet Joint Injection Lumbar Side & Level: _____ <input type="checkbox"/> SI Joint</p> <h3>JOINT INJECTIONS</h3> <p><input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> Foot L / R <input type="checkbox"/> Other: _____ L / R</p> <p><input type="checkbox"/> Marcaine Only <input type="checkbox"/> Steroid Only <input type="checkbox"/> Marcaine & Steroid</p> <h3>X-RAY</h3> <p>(Walk-in or by appointment, 8:00am - 4:30pm, M-F) <input type="checkbox"/> Chest <input type="checkbox"/> Kub/Abdomen <input type="checkbox"/> Hip <input type="checkbox"/> Knee L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Other _____</p> |
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Patient Preparation

If you have any questions about patient preparation, please call us at 206.292.7734.

Contra indications include cardiac pacemakers, aneurysm clips, cochlear implants, pregnancy and/or metal in the eyes.

- MRI**
 Exams with oral sedation will require a driver to accompany patients.
 Abdomen/Liver/MRCP: Nothing to eat or drink for at least 4 hours prior to your exam.
 Enterography: Nothing to eat or drink for 4 hours prior to your exam. Arrive 1 hour prior to exam.
 Prostate: Nothing to eat or drink after midnight. Arrive 1 hour prior to exam.
 Rectal: Nothing to eat or drink after midnight. Arrive 1 hour prior to exam.

- CT**
 Abdomen and/or Pelvis: Nothing to eat for at least 2 hours prior to your exam. Drink plenty of **water**.
 Head, Neck and Chest: Nothing to eat for at least 2 hours prior to your exam. Drink plenty of **water**.
 Spine and extremities: No preparation necessary.

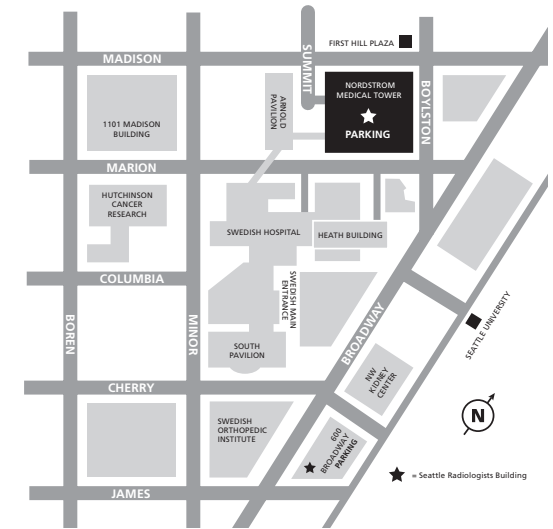
- EPIDURAL, NERVE ROOT BLOCK OR FACET JOINT INJECTION**
 Please contact our office if you are allergic to iodine (x-ray/ CT dye). Bring any pertinent x-rays or scans with you for comparison and to avoid x-rays being re-taken.
 All prescribed medications (except for blood thinners) should be taken as usual. A nurse will be contacting you to discuss pre-procedure instructions and restrictions. You must have a driver with you as there is a chance that you could experience temporary numbness and/or weakness in one or both legs. **You must speak to our nurse before having the exam to review other contraindicated medications. If she/he has not spoken to you, please take a moment to contact our nurse now by calling (206) 292-8525.**

- ARTHROGRAM**
 Please bring any pertinent x-rays or scans with you for comparison and to avoid x-rays being re-taken. Please contact our office if you are allergic to iodine (x-ray/ CT dye). It is not necessary to hold any medicine, including blood-thinners.

- MYELOGRAM/LUMBAR PUNCTURE**
 Please contact our office if you are allergic to iodine (x-ray/ CT dye). Please bring any pertinent x-rays or scans with you for comparison and to avoid x-rays being re-taken.
 Please be sure to have a driver with you.
 After the procedure, please plan to remain in a flat or reclined position at home until the next morning.
 No solid food after midnight the night before your exam. (For Myelograms - Do not consume anything containing caffeine 24 hours prior to the exam.) **You must speak to our nurse before having the exam to review other contraindicated medications. If she/he has not spoken to you, please take a moment to contact our nurse now by calling (206) 292-8525.**

- ULTRASOUND**
 Pelvic or OB<14 weeks: drink 32 oz of water 1 hour before test.
 Renal: Drink 32 oz of water 1 hour before test.
 Abdomen, gallbladder, aorta and organs: Nothing to eat or drink for 8 hours before test.

Driving Directions



Nordstrom Medical Tower

1229 Madison, Suite 900 Seattle, WA 98104

FROM THE NORTH

- Travel on I-5 South
- Take exit 165A toward James Street
- Turn left onto Cherry Street
- Take the first left onto 7th Avenue
- Take the third right onto Madison Street
- Take a right onto Summit Street to enter parking garage

FROM THE SOUTH

- Travel on I-5 North
- Take exit 164A for Dearborn Street toward James Street / Madison Street
- Follow signs for I-5 N / Vancouver BC / Madison Street / Convention Center
- Keep right at the fork, follow signs for Madison Street
- Turn right onto Madison Street
- Take a right onto Summit Street to enter parking garage

PET-CT - Patient Instructions

PRE-APPOINTMENT INSTRUCTIONS

In order to help us make your appointment more comfortable, please read the following instructions carefully. We ask that you dress warmly and try to avoid wearing anything with metal (including snaps, buttons and zippers). Keep in mind your visit can take up to 2.5 hours.

Pre-scan Instructions

- Nothing but water 8 hours before your test.
- If you are a diabetic, please bring your insulin with you to your appointment.
- Avoid exercise 24 hours prior to exam including long walks and yoga.
- Please remember to drink plenty of water prior to your exam.
- Take medications.
- Please call for additional instructions if you are breast feeding or have infants and/or toddlers.

