

**Patient Information**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

Patient Phone: (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_  Male  Female

Today's Date: \_\_\_\_\_ Appt Date: \_\_\_\_\_ Appt Time: \_\_\_\_\_

Insurance: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Insurance Authorization Number: \_\_\_\_\_

**Referring Provider**

Name (Please print): \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reason for Exam (\*Required information)**

\*Signs & Symptoms \_\_\_\_\_

\*Clinical Question? \_\_\_\_\_

Diagnosis/ICD-10 \_\_\_\_\_

**Optional Requests:**

(Note: Reports are automatically faxed to referring physician)

- Call report
- Call report while patient waits
- STAT**
- Send CD exam with patient
- Send CD of exam directly to referring physician
- Copy additional Provider: \_\_\_\_\_ reports to: Clinic: \_\_\_\_\_

Allergies? \_\_\_\_\_

Patient Pregnant?  Yes  No

**MRI**  PRN  with contrast  without contrast  without and with contrast  **CT**  PRN  with contrast  without contrast  without and with contrast

**Creatinine Test for contrast MRI and CT exams (Age > 60 or where clinically indicated)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Orbit x-ray to check for metal in eyes (where clinically indicated)   | <input type="checkbox"/> CTA _____         | <input type="checkbox"/> Oncology Case <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Brain <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left   | <input type="checkbox"/> Brain             | <input type="checkbox"/> C-Spine  |
| <input type="checkbox"/> MRA of Brain Specify: _____   | <input type="checkbox"/> CT KUB            | <input type="checkbox"/> T-Spine  |
| <input type="checkbox"/> C-Spine _____   | <input type="checkbox"/> CT IVP            | <input type="checkbox"/> L-Spine  |
| <input type="checkbox"/> T-Spine _____   | <input type="checkbox"/> Limited Sinus     | <input type="checkbox"/> Maxillofacial  |
| <input type="checkbox"/> L-Spine <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Sinus Multiplanar | <input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla                              |
| <input type="checkbox"/> Chest Specify: _____  | <input type="checkbox"/> Chest             | <input type="checkbox"/> Extremity  |
| <input type="checkbox"/> Abdomen _____   | <input type="checkbox"/> Abdomen           | <input type="checkbox"/> Upper <input type="checkbox"/> Lower                                   |
| <input type="checkbox"/> Pelvis _____  | <input type="checkbox"/> Pelvis            | <input type="checkbox"/> Right <input type="checkbox"/> Left                                    |
| <input type="checkbox"/> Arthrogram Joint: _____   | <input type="checkbox"/> CT Colonography   | Specify: _____  |
| <input type="checkbox"/> MRCP  | <input type="checkbox"/> Other CT: _____   | <input type="checkbox"/> 3D Reconstruction Needed   |
| <input type="checkbox"/> 3D Reconstruction needed  |  |   |
| <input type="checkbox"/> Other MRI: _____  |  |   |

**Breast MRI**

- MRI Breast without and with contrast
- MRI Guided Breast Biopsy  Right  Left
- Creatinine Test (Age >60 or where clinically indicated)**

**Therapeutic Joint Injection**

- Shoulder  Right  Left Injection Material:
- Hip  Right  Left  Steroid
- Knee  Right  Left  Anesthetic
- Other: \_\_\_\_\_  Right  Left

**ULTRASOUND**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Carotid Doppler  | <b>Abdomen</b>   | <b>Obstetrics</b>  |
| <input type="checkbox"/> Venous Doppler (DVT)<br>Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Lower | <input type="checkbox"/> Complete                        | <input type="checkbox"/> First Trimester   |
| <input type="checkbox"/> Pelvic (choose one below) <input type="checkbox"/> Add Doppler   | <input type="checkbox"/> Renal/Bladder                   | <input type="checkbox"/> Complete (Standard Ultrasound greater than 14 weeks gestation)  |
| <input type="checkbox"/> Transabdominal/Transvaginal  | <input type="checkbox"/> Renal/Bladder with Doppler      | <input type="checkbox"/> Follow-up Only (re-evaluation of fetal size, organ systems, or previous abnormality seen on other scan)                       |
| <input type="checkbox"/> Transabdominal Only  | <input type="checkbox"/> RUQ, Gallbladder, Liver, Kidney |  |
| <input type="checkbox"/> Transvaginal Only  | <input type="checkbox"/> Aorta                           | <input type="checkbox"/> Limited (Quick look - evaluates fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume) |
| <input type="checkbox"/> Scrotum <input type="checkbox"/> Scrotum with Doppler  | <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Biophysical Profile Only  |
| <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Appendix                        |  |
| <input type="checkbox"/> Other: _____   | <input type="checkbox"/> Bladder Only                    |  |

**DEXA**

- Bone Density Test
- Vertebral Fracture Assessment
- Appendicular (wrist)

**X-RAY**

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Chest
- KUB
- Other: \_\_\_\_\_
- Extremity: \_\_\_\_\_  
 R  L  Wt bearing

Radia Imaging Centers are comprehensive state-of-the-art diagnostic imaging centers; part of the largest private radiology practice in the Pacific Northwest. They are full-service, outpatient centers offering patients convenient scheduling, easy access, free parking and a comfortable environment, as well as the advanced technology required for accurate evaluations and diagnoses. Our dedicated, experienced staff treats every patient with respect and dignity. For physicians, we provide fast, efficient results reporting, electronic hospital interface for retrieving patient history and images, and access to more than 100 board-certified radiologists.

For your convenience, Radia Imaging Centers accept most insurance plans. If you are unsure about your coverage, please contact your benefit administrator. We offer convenient appointments, including same day scheduling for some exams.

**Swedish Radia Imaging Center At Edmonds**  
**21700 Highway 99**  
**Edmonds, WA 98026**

**Scheduling Phone: (425) 640-4942**

**Scheduling Fax: (425) 670-8690**

**Phone: (425) 640-4949**

**Fax: (425) 640-4940**

**HOURS**

<b>MRI Scans</b>	<b>Mon-Thu</b>	<b>7:00am-10:30pm</b>
	<b>Friday</b>	<b>7:00am-9:30pm</b>
	<b>Saturday</b>	<b>8:30am-5:00pm</b>
<b>CT Scans</b>	<b>Monday</b>	<b>9:00am-5:30pm</b>
	<b>Tue-Fri</b>	<b>9:00am-8:00pm</b>
	<b>Saturday</b>	<b>8:30am-5:00pm</b>
<b>Ultrasound</b>	<b>Monday</b>	<b>7:00am-7:00pm</b>
	<b>Tue-Fri</b>	<b>7:00am-8:00pm</b>
	<b>Saturday</b>	<b>8:30am-5:00pm</b>
<b>X-Ray</b>	<b>Mon-Fri</b>	<b>9:00am-7:00pm</b>
	<b>Saturday</b>	<b>8:30am-5:00pm</b>
<b>Dexa</b>	<b>Mon-Sat</b>	<b>8:30am-5:00pm</b>
<b>Therapeutic Joint Injections</b>	<b>Mon-Fri</b>	<b>9:00am-5:30pm</b>

*Hours are subject to change.*

*For current hours, please go to our website: [www.radiax.com](http://www.radiax.com)*



**From I-5 HEADING NORTH OR SOUTH:** Take Exit #179 (220th St SW). Turn west onto 220th SW, proceeding west to Highway 99. Turn right onto Highway 99 (Aurora) and stay in the left lane. Swedish Radia at Edmonds will be on your immediate left just after Starbucks and Dick's Drive-in.

**Patient Information**

For your MRI, CT or Ultrasound exam please arrive 15 minutes prior to your exam unless otherwise instructed. We require 24 hours notice for cancellations.

**Patient Instructions**

**Patients with other special needs (diabetes, renal impairment, claustrophobia, inability to lie still, wheelchair bound, etc.) should call in advance of appointment.**

**MRI**

Please notify the MRI facility for further instructions if:

- You are pregnant, or could be pregnant*
- You have a pacemaker or heart valve*
- You have a history of metal in the eyes*
- You have an aneurysm clip in the brain*
- You have any tattoos; including permanent eyeliner*

Please wear comfortable clothing. You may be asked to change into metal-free clothing.

Please check with your doctor for any medication directions.

**CONTRAINDICATIONS** include but are not limited to: The presence of cardiac pacemakers, ferromagnetic intracranial aneurysm clips, neurostimulators, cochlear implants, and certain other ferromagnetic foreign bodies in critical locations.

**CT Scan**

No solid foods or drink 4 hours prior to your scheduled exam time. You should take your daily medications with sips of water or juice.