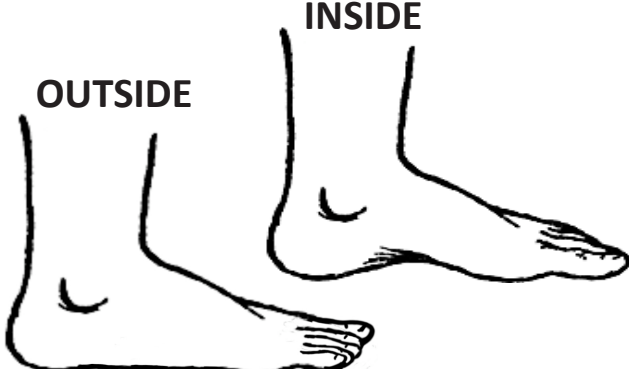


Patient Name: \_\_\_\_\_  Male  Female      DOB: \_\_\_\_\_  
 Phone: \_\_\_\_\_ /H \_\_\_\_\_ /C      Previous Studies?  No  Yes      Facility: \_\_\_\_\_  
 Insurance: \_\_\_\_\_      Auth Initiated?  No  Yes      Auth #: \_\_\_\_\_

**1. CHOOSE EXAM TYPE**

<b>CT:</b>	<input type="checkbox"/> With Contrast	<input type="checkbox"/> W/O Contrast	<input type="checkbox"/> Contrast at Radiologist Discretion	<input type="checkbox"/> 3D Reformats
<b>MRI:</b>	<input type="checkbox"/> With Contrast	<input type="checkbox"/> W/O Contrast	<input type="checkbox"/> Contrast at Radiologist Discretion	
	<input type="checkbox"/> 3T Requested (Kirkland only)		<input type="checkbox"/> T2 Mapping (Kirkland only)	
<b>Ultrasound:</b>	<input type="checkbox"/> LE Arterial Study	<input type="checkbox"/> LE Venous Study	<input type="checkbox"/> Other: _____	
<b>X-Ray:</b>	<input type="checkbox"/> Toes	<input type="checkbox"/> Foot	<input type="checkbox"/> Ankle	<input type="checkbox"/> Calcaneus
	<input type="checkbox"/> Tibia/Fibula	<input type="checkbox"/> Other (Mark Below) _____		

**2. DRAW/SELECT AREAS OF INTEREST**

	<p>Area of Interest:</p> <p>All Exams: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral</p> <p>MRI/CT: <input type="checkbox"/> Forefoot/Toes <input type="checkbox"/> Midfoot <input type="checkbox"/> Ankle/Hindfoot  <input type="checkbox"/> Calf <input type="checkbox"/> Other: _____</p> <p>MSK US: <input type="checkbox"/> Forefoot/Toes <input type="checkbox"/> Med Ankle <input type="checkbox"/> Lat Ankle  <input type="checkbox"/> Ant Ankle <input type="checkbox"/> Achilles/Calf <input type="checkbox"/> Plantar Fascia  <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Other _____</p> <p>Clinical Diagnosis &amp; Symptoms: _____</p>
--	--

**3. CHOOSE REPORT TYPE/METHOD OF DELIVERY**

<input type="checkbox"/> Routine	<input type="checkbox"/> Stat	<input type="checkbox"/> Copy Additional Provider	Name: _____
<input type="checkbox"/> Fax: _____	<input type="checkbox"/> Phone: _____	<input type="checkbox"/> Fax: _____	<input type="checkbox"/> Phone: _____
<input type="checkbox"/> Mail CD	<input type="checkbox"/> Send CD with Patient		

**4. ORDERING PROVIDER SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

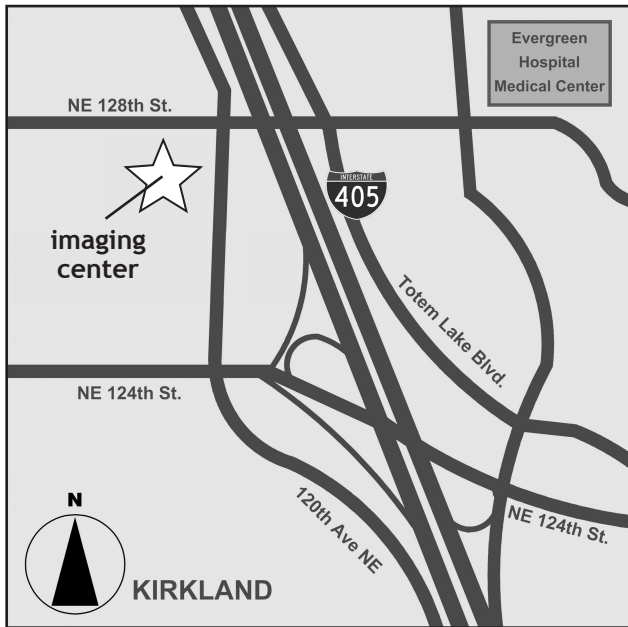
**5. CHOOSE IMAGING FACILITY**

Call Patient to Schedule     Patient Will Call to Schedule

<input type="checkbox"/> Radia Imaging 11521 NE 128 <sup>th</sup> St, Suite 200 Kirkland, WA 98034 Ph: (425) 952-6100 Fax: (425) 952-6150	<input type="checkbox"/> Radia Imaging 21700 Hwy 99 Edmonds, WA 98026 Ph: (425) 640-4949 Fax: (425) 640-4940
---	--

**Patient Screening Questions and Information**

<p><b>Does patient have any metal and/or implants in the body/head?</b> (i.e. pacemaker, stents, clips, wires, IUD, replacements, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, specify: _____</p>	<p><b>Is patient claustrophobic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes:</p> <p><input type="checkbox"/> Oral (Provider gives oral Rx to pt.)</p> <p><input type="checkbox"/> IV, Conscious sedation (driver needed)</p> <p><input type="checkbox"/> IV, General Anesthesia (driver needed)</p>	<p><b>Creatinine Requirements (MRI Contrast Only)</b> For patients requiring contrast and having any of the health concerns listed below, creatinine must be drawn within 6 weeks of the MRI exam.</p> <p><input type="checkbox"/> 60+ Years Old      <input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Diabetes              <input type="checkbox"/> History of Renal Disease</p> <p><input type="checkbox"/> Liver Disease        <input type="checkbox"/> Current Chemo Patient</p> <p><input type="checkbox"/> Creatinine _____    <input type="checkbox"/> Please Draw Creatinine</p>
<p>Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		



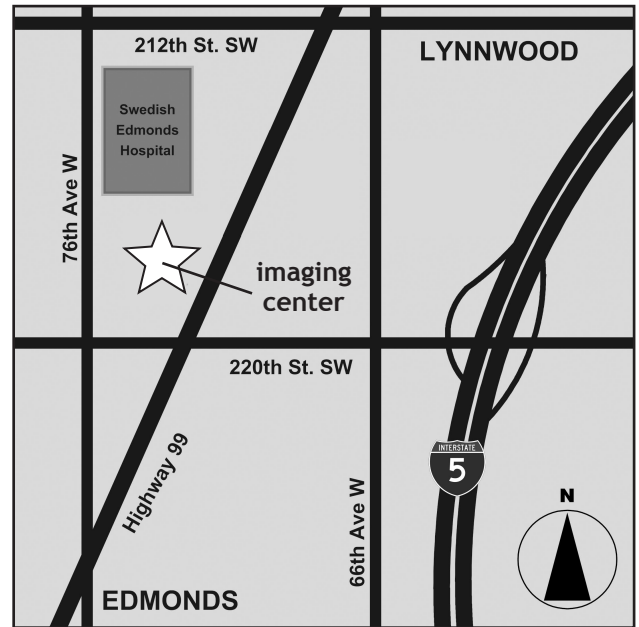
11521 NE 128th Street, Ste 200  
 Kirkland, WA 98034  
 Scheduling: 425-899-2831  
 Consultations: 425-952-6100

**Directions from I-405 SOUTH**

Take the 124th St. exit (#20). Turn right onto 124th St. Turn right onto 116th Ave. NE. Turn left at the light onto NE 128th St. The imaging center is on your left.

**Directions from I-405 NORTH**

Take the 124th St./Totem Lake Blvd exit (#20B). Stay to left for NE 124th St. Turn left onto 124th St. Turn right at the light onto 116th Ave. NE. Then turn left at the light onto NE 128th St. The imaging center is on your left.



21700 Highway 99  
 Edmonds, WA 98026  
 425-640-4949

**Directions**

From I-5 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 Avenue) and stay in the left lane. The imaging center will be on your immediate left just after Starbucks and Dick's Drive-in.