



OUTPATIENT IMAGING

750 Syringa, Ste. 105
 Post Falls, ID 83854
 Ph: (208) 262-2333
 Fax: (208) 262-2380

**PODIATRY IMAGING STUDY
 ORDER FORM**

Appt Date: ___/___/___
 Time: _____

Last Name: _____ First _____ MI _____ DOB: ___/___/___
 Phone: _____ /H _____ /C _____ Previous Studies? No Yes Facility: _____
 Insurance: _____ Auth Initiated? No Yes ***NWSH Obtain Auth** Yes
 Insurance ID: _____

*Chart Notes REQUIRED for Northwest Imaging Center to obtain prior authorizations.

PLEASE PRINT

Referring Physician(s): _____ CC Physician(s): _____ Fax: _____
 M.D. Signature: _____ Phone: _____
 Report: Stat
 Dr. Phone Call: _____

PATIENT INSTRUCTIONS

1. Please follow preparation on reverse side.
2. Please arrive 15 minutes prior to exam unless indicated on reverse.

EXAM REQUESTED

1. CHOOSE EXAM TYPE

CT:	<input type="checkbox"/> With Contrast	<input type="checkbox"/> W/O Contrast	<input type="checkbox"/> Contrast at Radiologist Discretion	<input type="checkbox"/> 3D Reformats
MRI:	<input type="checkbox"/> With Contrast	<input type="checkbox"/> W/O Contrast	<input type="checkbox"/> Contrast at Radiologist Discretion	
X-Ray:	<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

Area of Interest:

All Exams: Right Left Bilateral

MRI/CT: Forefoot/Toes Midfoot Ankle/Hindfoot

Calf Other: _____

Clinical Diagnosis & Symptoms:

Patient Screening Questions and Information

<p>Does patient have any metal and/or implants in the body/head? (i.e. pacemaker, stents, clips, wires, IUD, replacements, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, specify: _____</p>	<p>Is the patient claustrophobic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes:</p> <p><input type="checkbox"/> Oral (Provider gives oral Rx to pt.)</p>	<p>Creatinine Requirements (MRI Contrast Only) 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> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> 60+ Years Old</td> <td><input type="checkbox"/> Hypertension</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> History of Renal Disease</td> </tr> <tr> <td><input type="checkbox"/> Liver Disease</td> <td><input type="checkbox"/> Current Chemo Patient</td> </tr> <tr> <td><input type="checkbox"/> Creatinine _____</td> <td><input type="checkbox"/> Please Draw Creatinine</td> </tr> </table>	<input type="checkbox"/> 60+ Years Old	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> History of Renal Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Current Chemo Patient	<input type="checkbox"/> Creatinine _____	<input type="checkbox"/> Please Draw Creatinine
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<input type="checkbox"/> Creatinine _____	<input type="checkbox"/> Please Draw Creatinine									
<p>Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										

Appointment Information

Appointment or Exam Preparation Questions?

Call: (208) 262-2333

Pre-Exam Preparations

CT - Computed Tomography

For most CT exams you are not to eat anything for four hours prior to the exam. You are encouraged to sip clear fluids up to one hour prior to exam time. For abdomen and pelvis studies, you will be asked to drink a special liquid 30-60 minutes prior to the exam. For some CT procedures an I.V. contrast is necessary. If you are older than 60 years old, or diabetic, or have a known renal disease, your creatinine level must be documented within the last 30 days for all I.V. contrast procedures.

Appointment Time: _____ Check in at: _____

OUTPATIENT DIAGNOSTIC IMAGING PROCEDURE

Please use the Urgent Care entrance located at
750 Syringa Avenue. The Imaging Center is located in Suite 105.

