

RE QU IR ED	Priority <input type="checkbox"/> STAT <input type="checkbox"/> Routine <input type="checkbox"/> Call Critical Result to: _____ # _____	Height _____	Diagnosis: _____ Signs/Symptoms: _____ _____
		Weight _____	Diagnosis Codes: _____
			Insurance Name: _____ Authorization #: _____ Expires: _____
			<input type="checkbox"/> No Authorization required, Determined by (Name): _____

EXAM REQUESTED BREAST IMAGING *USE SEPARATE REFERRAL FORM (DI17167)*****

X-ray No appointment required for general x-ray, multiple x-ray locations (see reverse). Fluoroscopy and arthrograms requires appointments.

<input type="checkbox"/> Chest 2v	<input type="checkbox"/> Abdomen Acute	<input type="checkbox"/> Shoulder 3v R / L	<input type="checkbox"/> Knee 3v R / L	<input type="checkbox"/> L-Spine Complete	<input type="checkbox"/> C-Spine Complete
<input type="checkbox"/> Chest 1v	<input type="checkbox"/> Abdomen 2v	<input type="checkbox"/> Wrist 3v R / L	<input type="checkbox"/> Pelvis	<input type="checkbox"/> L-Spine Limited	<input type="checkbox"/> C-Spine Limited
<input type="checkbox"/> Ribs R / L	<input type="checkbox"/> Abdomen 1v (KUB)	<input type="checkbox"/> Hand 3v R / L	<input type="checkbox"/> Hip w/ Pelvis R / L		

Other (specify area): _____ Left Right

Fluoroscopy (Appt. Required) Esophagram Upper GI (Esophagus, Stomach, Duodenum) Small Bowel (follow through)
 Air Contrast Barium Enema Water soluble Contrast Enema **Other (specify):** _____

Arthrogram (Appt. Required) Joint: _____ MRI to follow CT to follow

Bone Density Date of Last Exam: _____ Central (spine/femur) to evaluate fracture risk.
 Peripheral (forearm); primary PTH, patients above 350# table limit, bilateral hip/spine hardware

<p>CT* (Requirements below) *Medication List required w/ Contrast*</p> <table border="0"> <tr> <td><input type="checkbox"/> Brain</td> <td><input type="checkbox"/> Orbits</td> <td><input type="checkbox"/> Facial Bones</td> <td><input type="checkbox"/> Sinuses</td> </tr> <tr> <td><input type="checkbox"/> Neck, Soft Tissue</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Pelvis</td> </tr> <tr> <td><input type="checkbox"/> Cervical Spine</td> <td><input type="checkbox"/> Thoracic Spine</td> <td><input type="checkbox"/> Lumbar Spine</td> <td></td> </tr> </table> <p>Other (specify): _____</p> <p>Specify Contrast for exam: <input type="checkbox"/> As medically indicated <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without IV contrast <input type="checkbox"/> With Oral Contrast <input type="checkbox"/> No Oral Contrast <input type="checkbox"/> Rectal Contrast</p> <p>CT Angio (with IV contrast) <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Renal <input type="checkbox"/> Bilateral Lower Ext. Other (specify): _____</p> <p>CT Guided Biopsy: _____</p>	<input type="checkbox"/> Brain	<input type="checkbox"/> Orbits	<input type="checkbox"/> Facial Bones	<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"/> Cervical Spine	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Lumbar Spine		<p>MRI* (Requirements below) *Medication List required w/ Contrast*</p> <p><input type="checkbox"/> Orbit X-rays (if history of eye injury with metal)</p> <table border="0"> <tr> <td><input type="checkbox"/> Brain</td> <td><input type="checkbox"/> IAC</td> <td><input type="checkbox"/> Soft Tissue Neck</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Pelvis</td> </tr> <tr> <td><input type="checkbox"/> Cervical Spine</td> <td><input type="checkbox"/> Thoracic Spine</td> <td><input type="checkbox"/> Lumbar Spine</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Hip L / R</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Sacrum</td> </tr> </table> <p>Extremity: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot Other (specify): _____</p> <p>Specify IV Contrast for above exam: <input type="checkbox"/> As medically indicated <input type="checkbox"/> With and without IV contrast <input type="checkbox"/> No IV contrast</p> <p>MRA: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Bilateral Lower Ext. Other (specify): _____</p>	<input type="checkbox"/> Brain	<input type="checkbox"/> IAC	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Lumbar Spine			<input type="checkbox"/> Hip L / R			<input type="checkbox"/> Sacrum
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***CT & MRI Requirements** Patients needing a contrast study with history of kidney disease, diabetes, chemotherapy in the last week, recent serious illness or over age 60, must have a serum creatinine test within 30 days of appointment:
 Serum Creatinine (Lab Order) or **Recent Lab Results:** Serum Creatinine: _____ Date: _____

Patients on Metformin: >> **Metformin Hold (Required)** first 48 hours **post** CT contrast injection.

Medication List Attached (w/ Contrast): Y N **Diabetic:** Y N >> **Diabetic Medication changes discussed:** Y N


Allergy to contrast: Y N **Pre medication instructions given:** Y N

Heart Surgery: Y N

Nuclear Medicine **Bone Scan** - Total Body Limited - specify area: _____ with: SPECT 3-phase
Other nuclear medicine scan (specify): _____

<p>Ultrasound</p> <p>Abdomen and Thyroid</p> <table border="0"> <tr> <td><input type="checkbox"/> Abdomen Complete</td> </tr> <tr> <td><input type="checkbox"/> Abdomen Limited, Single Organ</td> </tr> <tr> <td><input type="checkbox"/> Aorta</td> </tr> <tr> <td><input type="checkbox"/> Renal</td> </tr> <tr> <td><input type="checkbox"/> Renal w/ Bladder</td> </tr> <tr> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Thyroid with FNA</td> </tr> <tr> <td><input type="checkbox"/> Vascular (specify): _____</td> </tr> </table> <p>Other (specify): _____</p>	<input type="checkbox"/> Abdomen Complete	<input type="checkbox"/> Abdomen Limited, Single Organ	<input type="checkbox"/> Aorta	<input type="checkbox"/> Renal	<input type="checkbox"/> Renal w/ Bladder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid with FNA	<input type="checkbox"/> Vascular (specify): _____	<p>Pelvis</p> <table border="0"> <tr> <td><input type="checkbox"/> Pelvic w/ Transvaginal LMP _____</td> </tr> <tr> <td><input type="checkbox"/> Scrotal with Doppler</td> </tr> </table> <p>Other (specify): _____</p> <p>OB - LMP _____</p> <table border="0"> <tr> <td><input type="checkbox"/> OB < 14 Wks. w/ Transvaginal</td> </tr> <tr> <td><input type="checkbox"/> OB > 14 Wks. w/ Transvaginal PRN</td> </tr> <tr> <td><input type="checkbox"/> OB Ltd</td> </tr> <tr> <td><input type="checkbox"/> OB F/U</td> </tr> <tr> <td><input type="checkbox"/> Transvaginal (Cervix, low placenta, etc.)</td> </tr> </table> <p>Other (specify): _____</p>	<input type="checkbox"/> Pelvic w/ Transvaginal LMP _____	<input type="checkbox"/> Scrotal with Doppler	<input type="checkbox"/> OB < 14 Wks. w/ Transvaginal	<input type="checkbox"/> OB > 14 Wks. w/ Transvaginal PRN	<input type="checkbox"/> OB Ltd	<input type="checkbox"/> OB F/U	<input type="checkbox"/> Transvaginal (Cervix, low placenta, etc.)	<p>Vascular* *(exam details on back of form)</p> <table border="0"> <tr> <td><input type="checkbox"/> Carotid Duplex</td> </tr> <tr> <td>Arterial (Physiologic testing): <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext</td> </tr> <tr> <td><input type="checkbox"/> ABI Complete <input type="checkbox"/> ABI Limited</td> </tr> <tr> <td><input type="checkbox"/> w/exercise <input type="checkbox"/> w/exercise</td> </tr> <tr> <td>Arterial Duplex: <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext</td> </tr> <tr> <td><input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral: <input type="checkbox"/> Right <input type="checkbox"/> Left</td> </tr> <tr> <td><input type="checkbox"/> with ABI <input type="checkbox"/> with exercise ABI</td> </tr> <tr> <td>Venous Duplex: <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext</td> </tr> <tr> <td><input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Renal Arterial Duplex</td> </tr> </table> <p>Other (specify): _____</p>	<input type="checkbox"/> Carotid Duplex	Arterial (Physiologic testing): <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext	<input type="checkbox"/> ABI Complete <input type="checkbox"/> ABI Limited	<input type="checkbox"/> w/exercise <input type="checkbox"/> w/exercise	Arterial Duplex: <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext	<input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> with ABI <input type="checkbox"/> with exercise ABI	Venous Duplex: <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext	<input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Renal Arterial Duplex
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Provider Signature: _____ **Provider Name:** _____
(First Initial / Last Name / Title) Date / Time (Please Print)

 <p>OLYMPIC MEDICAL IMAGING CENTER 939 Caroline St. Port Angeles, WA 98362</p>	<p>Diagnostic Imaging Orders</p> <p>DI21183 8/19/2015</p> <p>Fax this order to: (360) 565-9001 Scheduling: Call 565-9003</p>	RE QU IR ED	<p>Patient Name: _____</p> <p>DOB: _____ Phone #: _____</p> <p>CC: _____</p> <p>Appointment Date/Time: _____</p>
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Patient Instructions

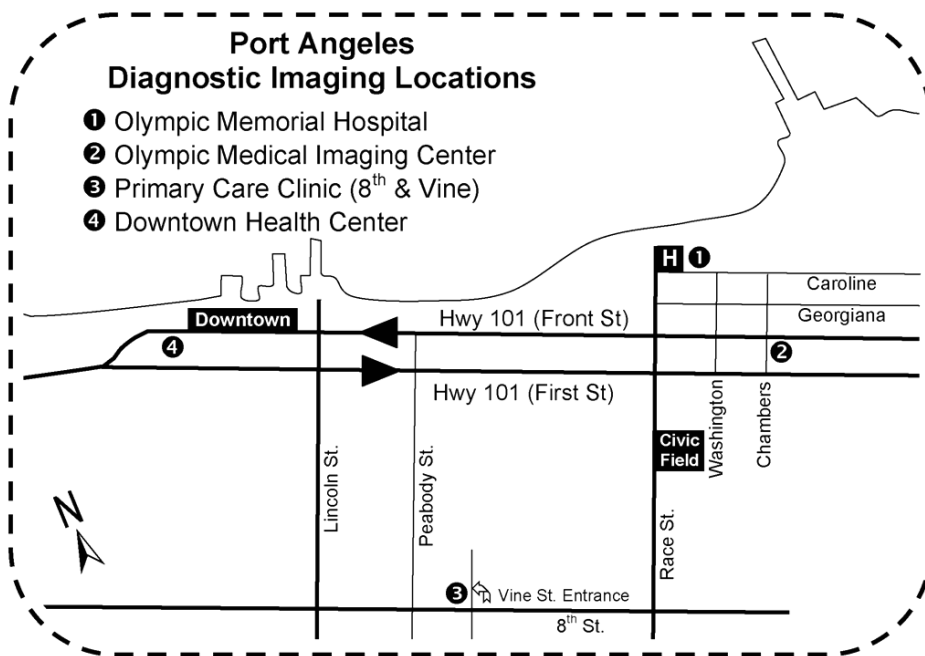
Thank you for choosing Olympic Medical Center for your diagnostic imaging needs.

- Please, no cell phones with you during the exam.
- During OB Ultrasound Exams: Two guests will be permitted with the patient. The guests must be 12 years of age or older.
- Scheduled patients accompanied by children under the age of 12 and without another adult present, will need to reschedule their appointment.

DETAILED INFORMATION FOR VASCULAR ULTRASOUND EXAMS

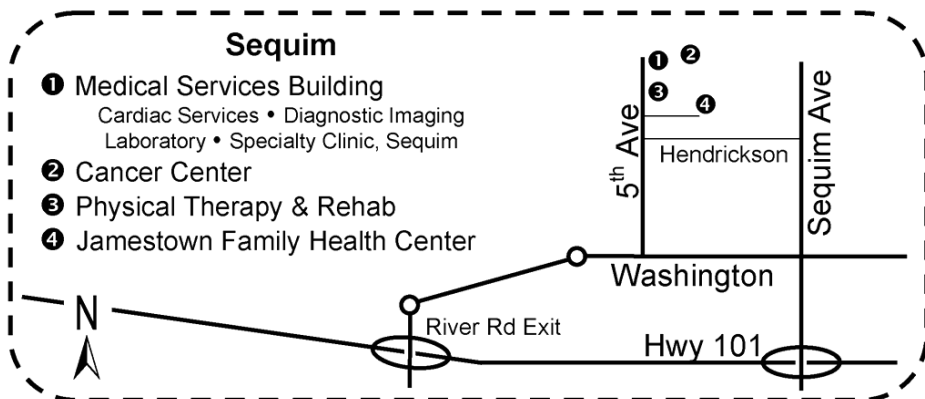
*Peripheral Arterial Evaluations	** Peripheral Venous Evaluations
Lower Extremity Arterial includes: Physiologic testing (ABI's and/or treadmill exercise testing). Duplex – Lower Extremity ultrasound for stenosis/atherosclerosis	Lower Extremity Venous with duplex: DVT - femoro-popliteal, tibio-peroneal & great saphenous veins. Pre-Vein Ablation/Closure Evaluation for patients with planned therapeutic intervention
Upper Extremity Arterial includes: Physiologic Testing or Duplex as needed	Upper Extremity Venous with duplex: Extremity veins including response to compression & other maneuvers

Two convenient general X-ray locations in Port Angeles available (in addition to the hospital)



Port Angeles

- Olympic Memorial Hospital
939 Caroline St.
- Olympic Medical Imaging Center
1102 E Front St.
Mammography / Bone Density only
- Downtown Health Clinic
240 W. Front St., Suite
X-Ray Only, All walk-in's welcome
- OMP 8th Street Radiology
433 E. 8th St.
Use Vine Street Entrance
X-Ray Only, All walk-in's welcome



Sequim

- Medical Services Building
840 N. 5th Ave.,
Suite 1100
- Jamestown Family Health Center
808 N. 5th Ave.
X-Ray Only