EvergreenHealth

EvergreenHealth Scheduling: 425.899.2831
EvergreenHealth Fax: 425.899.2828
www.evergreenhealth.com/imaging

DIAGNOSTIC IMAGING
Exam Order Form

(See reverse side for addresses and maps.)

EVERGREEN RADIA IMAGING CENTER

Scheduling: 425.899.2831
EvergreenHealth Radia Fax: 425.952.6150
EvergreenHealth Radia Phone: 425.952.6100
www.radiax.com

PATIENT INFORMATION

Patient Name _____ (LAST) _____ (FIRST) _____ (MI)
Primary Phone _____ DOB _____ Height _____ Weight _____

Diagnosis & Symptoms-*Required* _____

❑ Call Patient to Schedule ❑ Patient will Call ❑ Confirm order has been received by: ❑ Fax ❑ Phone

ICD-10 #-Required _____

Insurance _____
ID/Claim # _____
Authorization # _____
Is exam due to an injury? ❑ Yes ❑ No
Date of Injury _____

REQUIRED FOR ALL CT & MRI EXAMS WITH CONTRAST *Except For Arthrograms*

1) Patients with the following indications require Creatinine lab prior to contrast exams. ❑ **NONE APPLY.**
   - ❑ Age >60
   - ❑ Multiple Myeloma
   - ❑ Hypertension Needing Medication
   - ❑ CHF
   - ❑ Chemotherapy
   - ❑ Prior Contrast within 72 Hours
   - ❑ Diabetes
   - ❑ Currently on IV Antibiotics
   - ❑ Renal Disease - *incl. Transplant, Cancer, Resection*
2) *Patients meeting above criteria having contrast exams require Creatinine Lab within past 30 days. CHECK ONE:*
   a) ❑ Date of Recent Creatinine Test _____ BUN _____ CREATININE _____
   b) ❑ Site to Perform Creatinine Test via ISTAT as Needed.
3) IV Contrast: Please circle below with exam. Previous Contrast Reaction ❑ Yes ❑ No

MRI SCAN *Circle Desired Contrast*

❑ Brain	WO	W/WO	PRN
❑ Abdomen	WO	W/WO	PRN
❑ Cervical Spine	WO	W/WO	PRN
❑ Thoracic Spine	WO	W/WO	PRN
❑ Lumbar Spine	WO	W/WO	PRN
❑ Pelvis	WO	W/WO	PRN
❑ Breast		W/WO	PRN
❑ Breast Silicone Implant Eval. - *WO/Contrast*			
❑ Extremity	WO	W/WO	PRN

Indicate Body Part _____ R L BIL

❑ Arthrogram to Include Contrast Injection

Indicate Joint _____ R L BIL

❑ _____ WO W/WO PRN

CT SCAN *Circle Desired Contrast*

❑ Chest	WO	W	PRN
❑ Abdomen	WO	W	PRN

NOTE: CT Abdomen Only Covers to Iliac Crest

❑ Pelvis	WO	W	PRN
❑ Chest/Abdomen/Pelvis	WO	W	PRN
❑ Chest/Abdomen	WO	W	PRN
❑ Abdomen/Pelvis	WO	W	PRN
❑ Head	WO	W/WO	PRN
❑ Soft Tissue Neck	WO	W	PRN

- ❑ Chest Angio PE - *IV Contrast Mandatory*
- ❑ Chest Angio Aorta - *IV Contrast Mandatory*
- ❑ Abdomen/Pelvis Angio - *IV Contrast Mandatory*
- ❑ Myelogram to Include Injection
  - ❑ Cervical ❑ Thoracic ❑ Lumbar
- ❑ Extremity WO W PRN

Indicate Body Part _____ R L BIL

Circle if: MAKO or CONFORMIS

❑ _____ WO W PRN

REPORT/FILM/CD REQUEST

❑ **ROUTINE** ❑ Call Report # _____
❑ **STAT** ❑ Fax Report # _____
❑ Call Report/Patient Waiting
❑ Patient to Return with CD
❑ CC Report to Another Doctor:

_____
_____
_____

BONE DENSITOMETRY/DXA

- ❑ Z13.820 - *Screening for Osteoporosis*
- ❑ M85.9 - *Disorder of bone density and structure, unspecified*
- ❑ M85.10 - *Age-related osteoporosis without current pathological fracture*
- ❑ _____

NUCLEAR MEDICINE

- ❑ Bone Scan - Whole Body
- ❑ Bone Scan - 3 Phase
- ❑ HIDA
- ❑ Gastric Emptying
- ❑ Thyroid Uptake Scan
- ❑ SPECT CT

Body Part _____

❑ _____

ULTRASOUND

- ❑ Abdomen Complete
- ❑ Abdomen- RUQ only
- ❑ Pelvis - *Transvaginal & Transabdominal* ❑ *w/Doppler*
- ❑ Pelvis - *Transvaginal Only* ❑ *w/Doppler*
- ❑ Pelvis - *Transabdominal Only* ❑ *w/Doppler*
- ❑ Renal
- ❑ Thyroid
- ❑ LOWER Venous Doppler R L BIL
- ❑ UPPER Venous Doppler R L BIL
- ❑ Carotid Doppler
- ❑ OB - *First Trimester, Up to 11 Weeks: Transvaginal & Transabdominal*
- ❑ Scrotum ❑ *w/Doppler*
- ❑ _____

XRAY

- ❑ Chest - *PA and LAT*
- ❑ Abdomen ❑ 1 View ❑ 2 View
- ❑ Spine
  - ❑ Cervical ❑ Thoracic ❑ Lumbar
- ❑ Pelvis
- ❑ Metastatic Bone Survey
- ❑ Hip R L BIL
- ❑ Extremity _____ R L BIL
- ❑ Fluoro/Injection _____
- ❑ _____

REFERRING DOCTOR

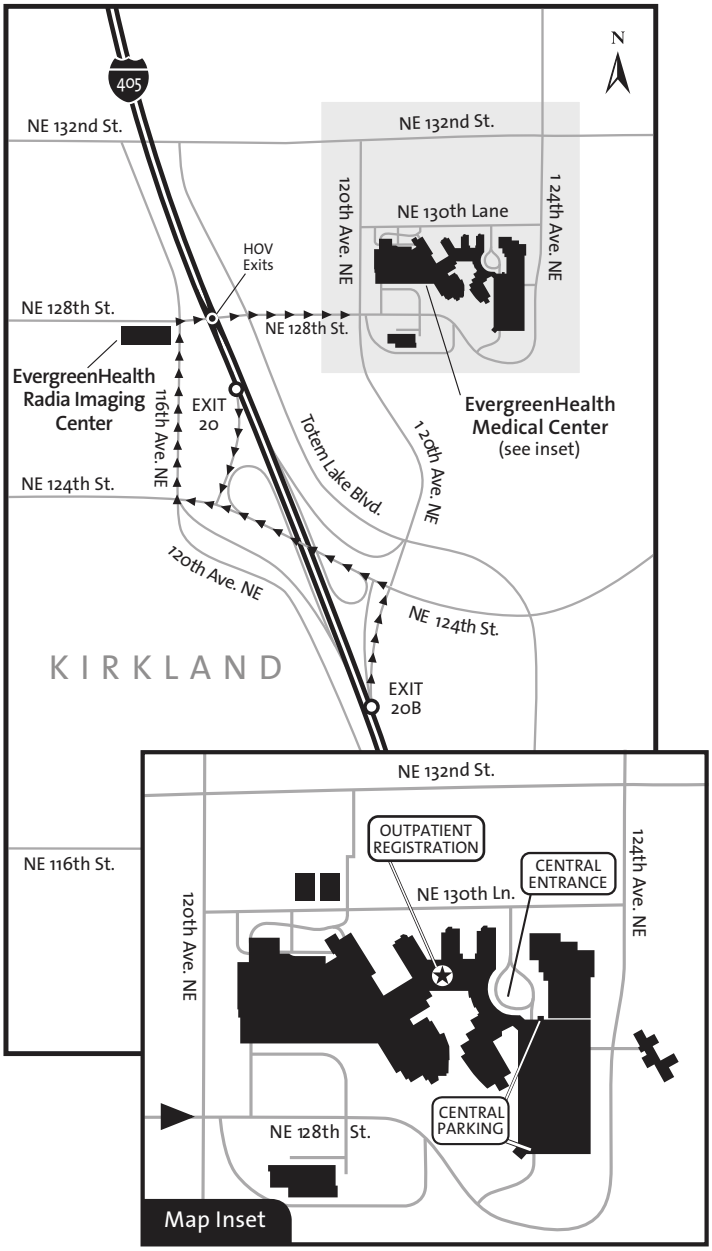
Name _____ Phone _____ Fax _____

Signature-*Required* _____ Date-*Required* _____

NOTES

_____
_____

DEC-18



KIRKLAND

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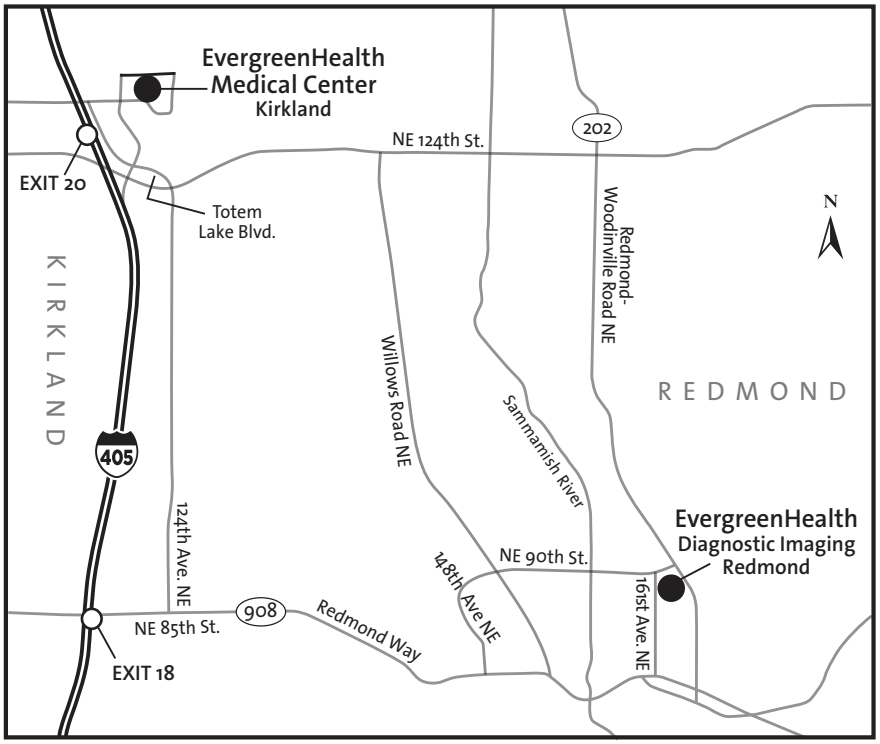

REDMOND

EvergreenHealth
Diagnostic Imaging - Redmond
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