SEATTLE RADIOLOGY

PODIATRY IMAGING STUDY
ORDER FORM

Patient Name: _____ ☐ Male ☐ Female DOB: _____

Phone: _____ Previous Studies? ☐ No ☐ Yes Facility: _____

Insurance: _____ Auth Initiated? ☐ No ☐ Yes Auth #: _____

Clinical Diagnosis & Symptoms:

_____

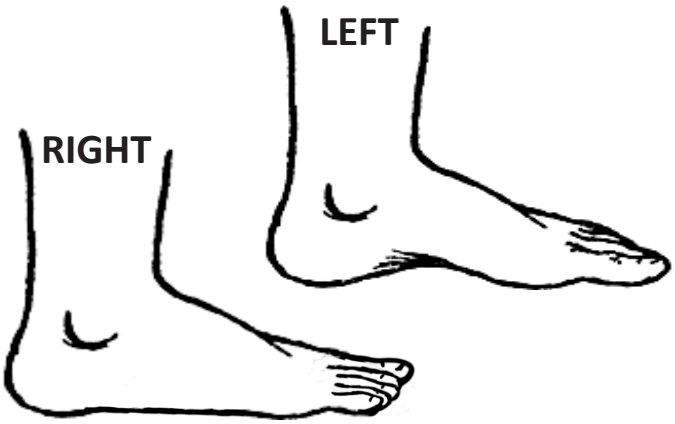
_____

Seattle Radiology
1229 Madison Street, Suite 900
Seattle, WA 98104
Main 206.292.6233 **Fax** 206.292.6372

1. *CHOOSE EXAM TYPE*

CT:	☐ With Contrast	☐ W/O	☐ Contrast at Radiologist Discretion	☐ 3D Reformats
MRI:	☐ With Contrast	☐ W/O Contrast	☐ Contrast at Radiologist Discretion	
Ultrasound:	☐ LE Arterial Study ☐ LE Venous Study	☐ MSK	☐ Other: _____	
Ultrasound Procedures:	☐ Tarsal Tunnel Block ☐ Sinus Tarsi Injection	☐ Plantar Fascia Steroid Injection	☐ Intermetatarsal Bursal Steroid Injection	☐ Neuroma Alcohol Sclerosing Injection
X-Ray:	☐ Toes ☐ Foot	☐ Ankle	☐ Calcaneus	☐ Tibia/Fibula ☐ Other (Mark Below)
Fluoroscopy Injections:	☐ Joint Injection ☐ MRI Arthrogram	Specify Joint: _____ Specify Joint: _____	☐ Marcaine	☐ Steroid

2. *DRAW/SELECT AREAS OF INTEREST*



Area of Interest:

All Exams: ☐ Right ☐ Left ☐ Bilateral

MRI/CT: ☐ Forefoot/Toes ☐ Midfoot ☐ Ankle/Hindfoot ☐ Calf ☐ Other: _____

MSK US: ☐ Forefoot/Toes ☐ Med Ankle ☐ Lat Ankle ☐ Ant Ankle ☐ Achilles/Calf ☐ Plantar Fascia ☐ Soft Tissue ☐ Other _____

3. *CHOOSE REPORT TYPE/METHOD OF DELIVERY*

☐ Routine	☐ Stat	☐ Copy Additional Provider	Name: _____
☐ Fax: _____	☐ Phone: _____	☐ Fax: _____	☐ Phone: _____
☐ Mail CD	☐ Send CD with Patient		

4. *ORDERING PROVIDER SIGNATURE:* _____ Date: _____

PLEASE PRINT NAME: _____ Phone: _____