

21601 76th Ave West

Edmonds WA 98026

Outpatient Imaging Request

Edmonds

Phone: 425-640-4260 Fax: 425-640-4472

Please bring this referral form with you to your appointment Patient Access/Registration is located on the east side of the Swedish/Edmonds Hospital Building

PATIENT INFORMATION

Last First MI Patient Phone: (Home)	Patient Name:			Age:Date of Birth:			
Insurance:	Last	First		MI			
Referring physician:	Today's Date:Appt D	Date:		ICD9 Code:			
Allergies: If yes: Icali report INO Call report while patient waits If yes: Icali report while patient waits If yes: Icali report while patient waits Send Exam with patient If OD Film Excessive pain? Peter Send Exam with patient If OD Film Patient pregnant? Yes No Dr	Insurance:		_	Reason for Exan	n/Clinical History:		
□ Call report while patient waits □ Charle program with patient □ Charle program with patient □ No Send Exam with patient □ CO ¬ Film Patient program with patient No Send Exam with patient □ CO ¬ Film Patient program with patient No □ Corp additional recuty to referring physician □ NUCLEAR MEDICINE □ □ Dr	Optional Requests: (Note: Reports are automatically faxed or mailed to referring physician)			Relevant previou If yes:	us imaging studies?	□ Yes	□ Pt will bring
Send Exam with patient CD Film Patient prognant? Yes No Send Exam with patient Copy additional reports to: NUCLEAR MEDICINE Exam: Image: Copy additional reports to: NUCLEAR MEDICINE Dr	-			Excessive pain?			
□ Send Exam directly to referring physician □ Copy additional reports to: □ Dr				-			
□ Copy additional reports to: Dr							
Dr				NUCLEA	R MEDICINE		
Clinic:							
Fax: PET/CT For PE/CT referral information please contact 425-640-4260 MRI EXAM REQUESTED MRI Faxin Upper Extremity Right Left Gadolinium? PR Yes No Does patient have: Aneurysm Clip Yes No MRA of Brain Specify:							
For Pet/CT referral information please contact 425-640-4260 MRI EXAM REQUESTED Brain Upper Extremity Right Left Gadolinium? PR Yes No Does patient have: Aneurysm Clip Yes No Metal in Eyes Yes No Metal in Eyes Yes No Metal in Eyes Yes No C Spine				PET/CT			
Brain Upper Extremity Right Left Gadolinium? PR Yes No Does patient have: MRA of Brain Specify:				For Pet/C	T referral informati	ion please contact	425-640-4260
■ MRA of Brain Specify: Aneurysm Clip Yes No ■ C-Spine	MRI EXAM REQUESTED			•			
C-Spine	□ Brain □ Upper Extremity	🗆 Right 🗆 Left	Gadolinium?	$\square PR \square$	Yes 🗆 No	Does patient ha	ive:
□ T-Spine nonth is required if patient has: Pacemaker □ Yes □ No □ Lower Extremity □ Right □ Left Diabetes □ Yes □ No □ Abdomen	□ MRA of Brain Specify:					Aneurysm Clip	\Box Yes \Box No
L.Spine Lower Extremity Right Left Diabetes Yes No Other implanted electronic device Chest Specify: Abdomen	□ C-Spine		A BUN and	creatinine within	one	Metal in Eyes	\Box Yes \Box No
Chest Specify: Abdomen	□ T-Spine		month is requ	uired if patient ha	s:	Pacemaker	\Box Yes \Box No
Abdomen Age > 60 Yes No Pelvis Cratinine: Cratinine: Other MRI Cratinine: Date: Date: Date: both to and from the appointment Date: Sinus C-spine Head C-spine A BUN and creatinine within one Sinus T-Spine A BUN and creatinine within one CT KUB L-Spine Thorax Extremity Abdomen Upper Lower Age > 60 Yes No Cratinine: Sinus Cratinine: Sinus Crist Diabetes Pelvis Renal disease Yes No Creatinine: Sinus Crist Creatinine: Sinus Crist Renal C-spine Maxillofacial Diabetes Diabetes Yes No Lumbar Spine Abdomen Upper Lower Age > 60 Abdomen Obstetrics Creatinine: Other: ULTRASOUND EXAM REQUESTED Abdomen Obstetrics Gallbladder >14 weeks Gallbladder >14 weeks Renal FAS Fetal Anatomic Screening Renal FAS Fetal Anatomic Screening Renal Limited follow-up	□ L-Spine □ Lower Extremity	🗆 Right 🗆 Left	Diabetes	□ Yes	🗆 No	Other implante	d electronic device
Pelvis BUN:	□ Chest Specify:		Renal di	sease 🗆 Yes	🗆 No		\Box Yes \Box No
Other MRI Creatinine:	Abdomen		Age > 60) 🗆 Yes	🗆 No	Claustrophobia	\Box Yes \Box No
Date: both to and from the appointment CT EXAM REQUESTED X-RAY CTA	□ Pelvis		BUN:				
CT EXAM REQUESTED X-RAY CTA	Other MRI		Creatinine:			be given. Patient must have a ride	
CT EXAM REQUESTED X-RAY CTA		Date:			both to and from the appointment		
Head C-spine Sinus Skull CT KUB L-Spine months is required if patient has: Cervical Spine Cervical Spine Thoracic Spine Thorax Extremity Diabetes Yes No Lumbar Spine Abdomen Upper Lower Age >60 Yes No KUB Pelvis Right Left BUN: Extremity: Extremity: Abd/Pelvis Combo Right Left BUN: Creatinine: Other: Other CT: Other CT: Obstetrics Miscellaneous Hernia Gallbladder >14 weeks Appendix Appendix Renal FAS Fetal Anatomic Screening Thyroid Thyroid Aorta Limited follow-up Limited follow-up Scrotum					X-RAY		
Sinus T.Spine A BUN and creatinine within one □ Skull CT KUB L-Spine months is required if patient has: □ Cervical Spine Thorax Extremity Renal disease Yes □ No Abdomen Upper Lower Age >60 Yes □ No Abd/Pelvis Combo Right Left BUN: □ □ R L Wt bearing Other CT: ULTRASOUND EXAM REQUESTED Distetrics Miscellaneous □ Hernia Gallbladder 0 >14 weeks □ Appendix □ Appendix Renal Extre □ FAS Fetal Anatomic Screening □ Thyroid □ RuQ, i.e. Liver □ General (EFW) □ Scrotum	CTA These exams include	le 3D reconstruction	IV contr	ast? 🗆 Yes	🗆 No	□ Chest	
CT KUB L-Spine Thorax Extremity Abdomen Upper Right Left Abd/Pelvis Combo Right Other CT: Obsettrics ULTRASOUND EXAM REQUESTED Abdomen Other CT: Other CT: Diabetes Pelvis Right Left BUN: Creatinine: Date: Other CT: VLTRASOUND EXAM REQUESTED Second Perform Obsettrics Miscellaneous Hernia Appendix Renal FAS Fetal Anatomic Screening RuQ, i.e. Liver Aorta Ct Limited follow-up	\Box Head \Box C-spine					Sinus	
CT IVP Maxillofacial Thorax Extremity Abdomen Upper Pelvis Right Abd/Pelvis Combo Extremity Other CT: Creatinine: ULTRASOUND EXAM REQUESTED Creatinine: Complete Complete Renal >14 weeks Renal FAS Fetal Anatomic Screening RUQ, i.e. Liver General (EFW) Aorta Limited follow-up	-						
□ Thorax □ Extremity Renal disease □ No □ Lumbar Spine □ Abdomen □ Upper □ Lower Age >60 □ Yes □ No □ KUB □ Pelvis □ Right □ Left BUN:	□ CT KUB □ L-Spine		months i	s required if patie	ent has:	•	
Abdomen □ Upper □ Lower Age >60 Yes No □ KUB Pelvis □ Right □ Left BUN: □ Extremity: Abd/Pelvis Combo □ R □ L Wt bearing Other CT: □ ULTRASOUND EXAM REQUESTED □ Other: □ Other: Abdomen Obstetrics Miscellaneous □ Complete □ <14 weeks			Diabetes	□ Yes	□ No	-	
Pelvis Right Left BUN: Extremity: Abd/Pelvis Combo Creatinine: R L Wt bearing Other CT: Date: Other: Other: ULTRASOUND EXAM REQUESTED Obstetrics Miscellaneous Abdomen Obstetrics Miscellaneous Complete <14 weeks			Renal di		□ No	-	
Abd/Pelvis Combo Creatinine:			U				
Other CT: Date:	-	□ Left	BUN:			-	
ULTRASOUND EXAM REQUESTED Abdomen Obstetrics Miscellaneous Complete I <14 weeks						\Box R \Box L	Wt bearing
Abdomen Obstetrics Miscellaneous Complete <14 weeks	$\Box \text{Other CT:} $		Date:			□ Other:	
Abdomen Obstetrics Miscellaneous Complete <14 weeks	LII TRASOUND EXAM REQUESTE						
Complete - <14 weeks						Miscellaneous	
Gallbladder ->14 weeks - Appendix Renal - FAS Fetal Anatomic Screening - Thyroid RUQ, i.e. Liver - General (EFW) - Scrotum Aorta - Linited follow-up - Scrotum							
Renal Image: FAS Fetal Anatomic Screening Image: Thyroid RUQ, i.e. Liver Image: General (EFW) Image: Scrotum Aorta Image: Limited follow-up Image: Scrotum	-						
□ RUQ, i.e. Liver □ General (EFW) □ Scrotum □ Aorta □ Limited follow-up							
□ Aorta □ Limited follow-up		-				•	
	-						
	□ Pelvic non-OB						

Please see other side for patient preparation instructions and driving directions. 24-hour notice required for all cancellations.

CT SCAN

ABDOMEN AND PELVIS SCAN

- 1. Patient must pick up oral contrast at the Radiology Front Desk (Swedish/Edmonds Hospital) a day before the scheduled examination, unless you have been given contrast by your private physician.
- For Abdomen CT scan, drink the contrast 1 hour prior to scheduled scan.
 For Pelvic CT scan, drink the contrast 2 hours prior to scheduled scan.
- 3. Patient must arrive 15 minutes prior to their scheduled appointment.
- 4. Nothing to eat 4 hours prior to study. Clear liquids up to 2 hours prior to exam.

HEAD / NECK / CHEST WITH CONTRAST

1. Clear liquid diet for 2 hrs prior to the exam. Liquids include clear juices such as apple, cranberry and grape, clear soups (strained), jello, coffee or tea. No milk products or carbonated beverages.

SPINE / EXTREMITIES / SINUSES/ HEAD WO CONTRAST

No preparation needed.

IV CONTRAST

If age 60 or older, history of diabetes or history of kidney disease, BUN/Creatinine labs within 30 days are required.

RADIOLOGY / XRAY

UGI, ESOPHAGUS, SMALL BOWEL

- 1. Nothing to eat or drink 12 hours prior to your examination. This includes all food and liquids.
- 2. No smoking.

BARIUM ENEMA

- 1. Clear liquid diet for 2 days prior to the exam.
- 2. At 3 pm the day before your exam drink 10 oz magnesium citrate.
- 3. At 6 pm the day before exam take 4 Dulcolax tablets.
- 4. 2 hours before the exam use 1 Dulcolax suppository. Try to retain for 15 minutes.
- 5. Nothing but water after midnight until your exam is completed.

INTRAVENOUS PYELOGRAM (IVP)

- 1. Follow your Urologist's prep instructions.
- 2. Other patients must stay on clear liquids 1 day before the scheduled exam.
- 3. At 3 PM on the day before the exam, take 10 oz of Magnesium Citrate.
- 4. Stay on clear liquids until time of appointment

ULTRASOUND

ABDOMEN, GALLBLADDER, LIVER

1. For best results nothing to eat or drink 8 hours before exam

PELVIS, OB, KIDNEY

- 1. Drink 24 ounces of water 45 minutes prior to the examination.
- 2. Do not empty your bladder.

MAGNETIC RESONANCE IMAGING

For all types of abdominal MRI exams, nothing to eat for 4 hours prior to the examination. Clear liquids are OK.

Please alert the MRI technologists if you have any of the following:

Pacemaker Aneurysm clips Head Surgery Heart Surgery Ear Implants Tattooed Eyeliner Metal in Eyes Removable Dental Work Other Metal in the Body Electronic Implants

DRIVING DIRECTIONS TO SWEDISH/EDMONDS CAMPUS

North on I-5

Heading northbound on I-5, take the 220th St. Exit (#179). Turn left at the light and follow to Hwy 99. Turn right and continue to 216th. Turn left and continue up the hill to the Swedish/Edmonds Campus

South on I-5

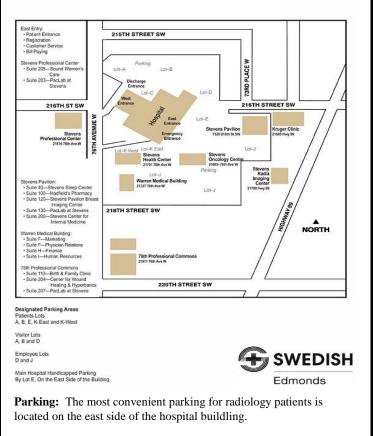
Heading southbound on I-5, take the 220th St. Exit (#179). Turn right and follow 220th to Hwy 99. Turn right and continue to 216th. Turn left and continue up the hill to the Swedish/Edmonds Campus.

North on Hwy 99

Heading northbound on Hwy 99, turn left on 216th and continue up the hill to the Swedish/Edmonds campus.

South on Hwy 99

Heading southbound on Hwy 99, turn right onto 216th and continue up the hill to the Swedish/Edmonds campus.



Patient Registration is located on the 1st floor just inside the double doors on the East side of the hospital.

Please have your patient bring any outside films and reports to Swedish/Edmonds Hospital Radiology Department. For more detailed prep instructions you may contact our scheduling department at 425-640-4260. Radiology Receptionist 425-640-4254.