

RADIOLOGY PHYSICIAN ORDER

1700 13th Street, Everett, WA 98201
Scheduling Phone (425) 258-7000, Option 3
Scheduling Fax (425) 258-7035

- Centralized Scheduling to call patient
 Patient will call to schedule

PATIENT INFORMATION

Appt. Date: _____ Appt. Time: _____

Patient Name: _____ Phone: _____ Age: _____ Date of Birth: _____
Last First Middle Initial

REFERRING PHYSICIAN

Name: _____ Phone: _____

Clinic: _____ Fax: _____

Physician Signature: _____

Diagnosis Code (Required information): Clinical History / Signs and Symptom:
ICD 10 _____

Relevant previous imaging studies? Yes No

1. Procedure Code _____
2. Procedure Description _____
3. Insurance Name _____
4. Subscriber Name _____
5. Subscriber ID Number _____
6. Authorization Number or please indicate if Authorization is pending or not required _____

CT

- | | |
|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Lumbar Spine |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Abdomen/Pelvis | <input type="checkbox"/> CT ABD |
| <input type="checkbox"/> CT KUB | <input type="checkbox"/> CT IVP |
| <input type="checkbox"/> Aortic CTA | <input type="checkbox"/> Pulmonary CTA |
| <input type="checkbox"/> Leg Length | |
| <input type="checkbox"/> Other CT: _____ | |
| <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast | |

X-RAY

- | | |
|---|---|
| <input type="checkbox"/> Chest | <input type="checkbox"/> Cervical Spine |
| <input type="checkbox"/> KUB | <input type="checkbox"/> Thoracic Spine |
| <input type="checkbox"/> Acute Abdominal Series | <input type="checkbox"/> Lumbar Spine |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Skull |
| <input type="checkbox"/> Extremity: _____ | |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wt. Bearing | |
| <input type="checkbox"/> Other X-Ray _____ | |

VASCULAR ULTRASOUND

- | | |
|---|--|
| <input type="checkbox"/> Carotid | |
| <input type="checkbox"/> Extremity – Venous | |
| <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper Ext <input type="checkbox"/> Lower Ext | |
| <input type="checkbox"/> Extremity – Arterial | |
| <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper Ext <input type="checkbox"/> Lower Ext | |
| <input type="checkbox"/> ABI (Ankle Brachial Index) <input type="checkbox"/> Resting <input type="checkbox"/> Exercise | |
| <input type="checkbox"/> Hemodialysis Graft Fistula | |
| <input type="checkbox"/> Aorta Iliac <input type="checkbox"/> Renal Arterial <input type="checkbox"/> Mesenteric | |
| <input type="checkbox"/> Other Vascular: _____ | |

OPTIONAL REQUESTS

- Call Report – Hold patient in dept.
 Call Report – Patient can go home.
 Send 1 Copy of Image CD with Patient
 AD (active duty) please send 2 Copies of Image CD with patient
 Copy additional reports to:
Dr. _____
Clinic: _____
Fax: _____

Patient Pregnant? Yes No

Allergies: _____

BUN / CREATININE PROTOCOL

Cell disease/multiple myeloma/60+years • BUN/creatinine lab values should be done preferably within 14 days but NO LONGER THAN 30 days out. That means any labs that are older than 30 days will have to be redrawn and have the results available before the test can be completed.

MRI

Does the patient have an implanted cardiac pacemaker? Yes No
If yes, please give the name and model of the pacemaker (if known): _____

Perform Exam with 3 T Unit _____

Perform Exam with 1.5 T Unit _____

- | | |
|--|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Cervical Spine |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Lumbar Spine |
| <input type="checkbox"/> Liver | <input type="checkbox"/> MRCP |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Female Pelvis |
| <input type="checkbox"/> Brain MRA | <input type="checkbox"/> Carotid MRA |
| <input type="checkbox"/> Arthrogram <input type="checkbox"/> Right <input type="checkbox"/> Left | |
| <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder | |
| <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Ankle | |
| <input type="checkbox"/> Other MRI: _____ | |
| <input type="checkbox"/> Without Contrast | |
| <input type="checkbox"/> With & Without Contrast | |

ULTRASOUND

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Aorta | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Inguinal Hernia |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Scrotum | <input type="checkbox"/> Other U/S: _____ |
| <input type="checkbox"/> OB <14 Wks w/ Transvaginal | <input type="checkbox"/> OB Limited | |
| <input type="checkbox"/> OB >14+ Wks Single or 1st Gestation | <input type="checkbox"/> OB Follow Up | |

Patient Instructions (if you have any questions, please call us directly at 425-404-5200)

MRI: Due to a strong magnetic field, please wear comfortable clothing without metal (zippers, snaps, buttons) if possible. Please remove any metal jewelry before arrival. Please let us know if you have an aneurysm clip or any implantable electronic device in your body such as a cardiac pacemaker, neurostimulator, or inner ear implant. Allow up to 60 minutes for your examination. For **MRI Pancreas** and **MRCP** exams the patient should have nothing to eat or drink 6 hours prior to their exam time. Regular medications can be taken with small amounts of water.

CT: Please do not eat any solid foods within 4 hours of your examination unless your doctor has told you IV contrast will definitely not be given. If receiving oral contrast for an abdominal/pelvic exam, please arrive 1 hour prior to the exam time to start drinking the contrast.

Directions to Providence Regional Medical Center Everett

Southbound 1-5: take exit 198 from interstate 5. This road becomes Broadway. **Turn right on 13th** and proceed 2 blocks.

As of October 21, 2019 Providence has instituted a pay for parking program.

The parking is available in the parking garage entrance on your left.

Northbound 1-5: take exit 195 from interstate 5. At the end of the exit ramp, follow the blue hospital signs.

Turn left on 13th and proceed 2 blocks.

As of October 21, 2019 Providence has instituted a pay for parking program.

The parking is available in the parking garage entrance on your left.

Check in at the 1st floor Radiology in the Cymbaluk Tower.

NOTE: Pediatric sedations may have special requirements. Please ask our schedulers at (425) 258-7000.

