

SWEDISH MEDICAL IMAGING

SWEDISH MILL CREEK IMAGING REQUISITION FORM

Phone: 425-357-3960 • Fax: 425-357-3961 • 13020 Meridian Ave. S., Everett, WA 98208

Today's date: _____

Patient information: (All fields are required)

Patient legal name: _____ Date of birth: _____
 Patient phone number: _____ Male Female Other: _____ Height: _____ Weight: _____
 Call patient to schedule Need interpreter (language): _____ Need assistive: Hearing Visual device
Pregnant? Yes No **Diabetic?** Yes No **Allergies?** Contrast Iodine Latex Other: _____
 Insurance/Plan: _____ Member #/ID: _____ Uninsured Self-pay
 Authorization #: _____ Valid date(s): _____ L & I, Claim #: _____

Ordering provider: (All fields are required)

Physician printed name: _____ NPI: _____ Phone: _____
 Signature: (required) _____ Date/Time: _____
 Clinic contact: _____ Clinic fax: _____
 In event of critical finding, contact: _____ Phone: _____

Reason for exam: (All fields are required)

ASAP Routine Symptoms/Diagnosis: _____
 Reason for exam: _____
 ICD-10: _____ CPT code(s): _____

Reports are always faxed. Fax **additional** report to: Dr. _____ Fax: _____

Prior films? No Yes, where? _____ If injured, date of injury: _____

Swedish Image Transfer Request Form: <https://www.swedish.org/services/medical-imaging/image-transfer-request>

Comments/Instructions: _____

Decision support Vendor (G code) _____ Adherence code (M modifier) _____ ID _____ Score _____

Exam ordered: (Patient preps and directions on back)

Does patient have any implants? No Yes, what and where _____

If ordering MR or CT: **IV contrast?** With Without Without and with **Creatinine:** _____ Date: _____

MRI	CT	Ultrasound	X-ray
<input type="checkbox"/> Brain <input type="checkbox"/> MS <input type="checkbox"/> IAC <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> Soft tissue neck Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Shoulder <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> MRCP (biliary) <input type="checkbox"/> Adrenal <input type="checkbox"/> Renal <input type="checkbox"/> Enterography <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Brain MRA <input type="checkbox"/> Neck MRA (carotids) <input type="checkbox"/> Extremity / Other MRI: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arthrogram	<input type="checkbox"/> Head <input type="checkbox"/> Sinus <input type="checkbox"/> Orbits <input type="checkbox"/> IAC <input type="checkbox"/> Soft tissue neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Adrenal <input type="checkbox"/> Enterography <input type="checkbox"/> CT IVP <input type="checkbox"/> CT KUB (renal stone) <input type="checkbox"/> Head <input type="checkbox"/> Neck CTA <input type="checkbox"/> Pulmonary CTA (PE) <input type="checkbox"/> Extremity / Other CT: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arthrogram	Abdomen <input type="checkbox"/> Complete <input type="checkbox"/> Ltd Pelvis <input type="checkbox"/> With <input type="checkbox"/> Without Transvag <input type="checkbox"/> Gallbladder <input type="checkbox"/> Appendix <input type="checkbox"/> Kidney/Bladder <input type="checkbox"/> Scrotum <input type="checkbox"/> Aorta <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft tissue mass _____ <input type="checkbox"/> Hernia _____ OB 1st trimester <input type="checkbox"/> With <input type="checkbox"/> WO Transvag <input type="checkbox"/> OB comp (FAS) <input type="checkbox"/> OB Ltd <input type="checkbox"/> OB follow-up (growth) <input type="checkbox"/> Biophysical profile <input type="checkbox"/> AFI LMP _____ EDC _____ <input type="checkbox"/> Other ultrasound: _____	<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Scoliosis <input type="checkbox"/> Leg length <input type="checkbox"/> Extremity / Other X-ray: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wt-bearing <div style="background-color: black; color: white; padding: 2px; text-align: center;">3D Digital Mammography</div> <input type="checkbox"/> Screening

Please fax order to: 425-357-3961. Thank you for choosing Swedish!

PATIENT INSTRUCTIONS

MRI

Our short-length, wide bore MRI scanner is a very comfortable scanner. Moreover, it offers very high image quality. We also let you select your own music for your scan to increase your comfort level. MRI scanners do not use radiation.

Please arrive 15 minutes before your exam. Patients should wear metal-free clothing or a hospital gown. Please remove all jewelry, watches, piercings, etc. There are no eating or drinking restrictions.

If patient is diabetic, BUN: _____ Date: _____.

If the patient is claustrophobic, medication may be given. You must have a ride to and from your appointment.

Does patient have?

Pacemaker/Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ferromagnetic prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ferromagnetic aneurysm clip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other implanted device	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal anywhere in body	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattoo/Body piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ortho pins/Screws/Rods/Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CT

Our CT scanner technology delivers up to 40% less radiation per dose than traditional CT scanners. We also use detailed protocols and other techniques to ensure your radiation dose is as small as possible.

Do not smoke, eat or drink for two hours prior to your exam. If you are receiving oral contrast, please arrive one hour before your exam. If you are receiving IV contrast, please arrive 15 minutes prior to your exam.

If patient is diabetic, BUN: _____ Date: _____.

ULTRASOUND

Our state-of-the-art equipment produces very clear 3D digital images using sound waves (no radiation).

Please arrive 15 minutes before your exam.

- For **abdomen studies**, do not eat or drink for eight hours prior to your exam (except water and necessary medications).
- For **kidney studies**, drink three 8 ounce glasses of water one hour before your exam and keep your bladder full.
- For **pelvis studies**, drink three 8 ounce glasses of water one hour before your exam and keep your bladder full.
- For **pregnancies** in the first 14 weeks drink three 8 ounce glasses of water one hour before your exam and keep your bladder full. For pregnancies after the first 14 weeks it is not necessary to have a full bladder.

Directions and map to Swedish Mill Creek campus

Traveling from I-5:

- Take the WA-96 E/128th Street SW exit — Exit 186.
- Turn right onto 128th Street SE/WA-96.
- Take the first right onto 3rd Avenue SE.
- Stay straight to go onto 130th Street SE.
- 130th Street SE becomes Meridian Avenue S.
- The Swedish Mill Creek campus is on the right.



SWEDISH MEDICAL IMAGING

Mill Creek

13020 Meridian Ave. S.
Everett, WA 98208
T 425-357-3920

Emergency Dept. (24 hours) 425-357-3910

Swedish Edmonds Lab 425-357-3930

swedish.org/services/medical-imaging

We do not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity or expression, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY:711)

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 888-311-9127 (TTY:711)

