

**EVERGREEN RADIA
IMAGING CENTER**

Scheduling: 425-899-2831
 Radia Fax: 425-952-6150
 Radia Phone: 425-952-6100
www.radiax.com

(See reverse side for address, map and directions)

*Please bring this referral form
with you to your appointment*

**CHIROPRACTIC
REQUEST FOR IMAGING**



Scheduling: 425-899-2831
 Fax: 425-899-2828
www.evergreenhealth.com/imaging
 (See reverse side for address, map and directions)

Patient Information: Appt. Date: _____ Appt. Time: _____
 Name: _____ Age: _____ Date of Birth: _____
 (Last) (First) (MI)
 Home Phone: _____ Work/Cell Phone: _____ Male Female
 Insurance: _____

Referring Physician:

Name: _____
 Clinic: _____
 Fax: _____
 Physician Signature: _____ Date: _____

Optional Requests:

- Call report
- Call report while patient waits
- Send CD with patient
- Send CD directly to referring physician
- Copy additional reports to:
 Doctor: _____
 Clinic: _____
 Fax: _____

Reason for Exam/Clinical History: _____

Exam Priority: Routine Urgent
 Patient Pregnant: Yes No
 Allergies: _____
 Patient Height: _____ Weight: _____
 Relevant previous imaging studies? Yes No
 If yes: Office will send Patient will bring

X-RAY

<input type="checkbox"/> Weight Bearing <input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right Extremity: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Leg Length Study	<input type="checkbox"/> Cervical Spine <input type="checkbox"/> 3V <input type="checkbox"/> Pillar <input type="checkbox"/> 5V Obliques <input type="checkbox"/> 5V Flex Ext <input type="checkbox"/> 7V	<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> 3V <input type="checkbox"/> 5V Obliques <input type="checkbox"/> 5V Flex Ext <input type="checkbox"/> Bi-Lat Bend	<input type="checkbox"/> Thoracic Spine <input type="checkbox"/> 2-3V <input type="checkbox"/> CT view/Swimmers	<input type="checkbox"/> Rib <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other: _____ _____ _____
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MRI

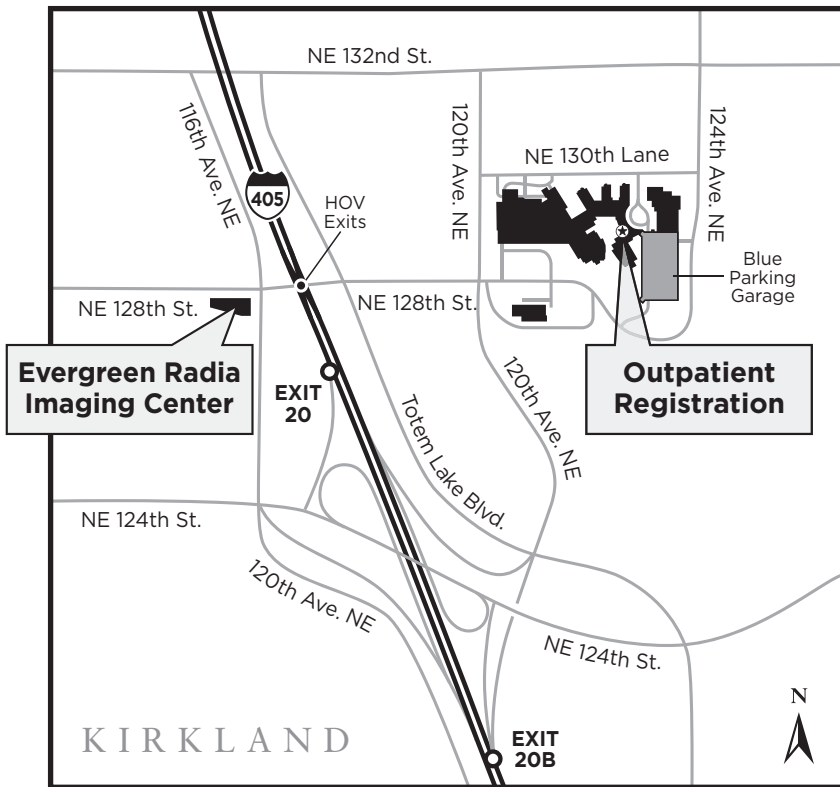
<input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Arthrogram <input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Arthrogram <input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Arthrogram <input type="checkbox"/> Ankle <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Lumbar Sacral Plexus <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Carotid MRA <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Pars/spondylosis (3T only) <input type="checkbox"/> Pelvis <input type="checkbox"/> Other MRI: _____	IV Contrast? <input type="checkbox"/> PRN <input type="checkbox"/> Yes <input type="checkbox"/> No BUN and Creatinine within one month is required if patient has: Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Age > 60? <input type="checkbox"/> Yes <input type="checkbox"/> No BUN: _____ Creatinine: _____ Date: _____	Does patient have: Aneurysm Clip? <input type="checkbox"/> Yes <input type="checkbox"/> No Metal in eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia? <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No Other implanted electronic device? <input type="checkbox"/> Yes <input type="checkbox"/> No
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CT	PAIN INJECTIONS
<input type="checkbox"/> Head <input type="checkbox"/> Sinus <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Myelogram <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Other CT: _____ <input type="checkbox"/> Thoracic Spine _____ <input type="checkbox"/> Lumbar Spine _____	IV Contrast? <input type="checkbox"/> Yes <input type="checkbox"/> No BUN and Creatinine within one month is required if patient has: Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Age > 60? <input type="checkbox"/> Yes <input type="checkbox"/> No BUN: _____ Creatinine: _____ Date: _____
	<input type="checkbox"/> Epidural Steroid Inj. (ESI) <input type="checkbox"/> Facet Injection <input type="checkbox"/> Select Nerve Root Block <input type="checkbox"/> Median Branch Block <input type="checkbox"/> Joint Pain/Steroid Inj. _____ _____

ULTRASOUND
 Specify: _____

DEXA
 Bone Density

Diagnostic Imaging Locations



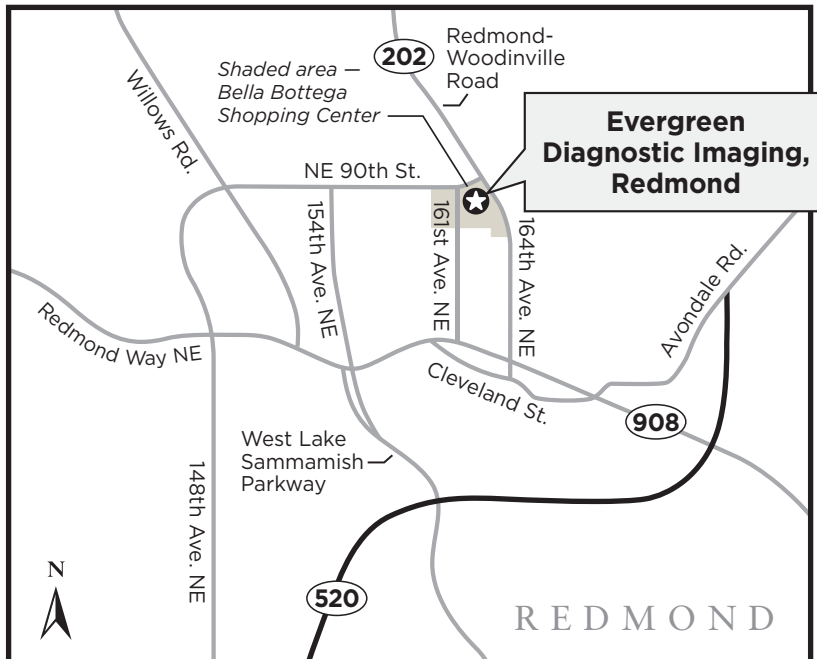
KIRKLAND

EvergreenHealth Medical Center Diagnostic Imaging

425.899.2831
12040 NE 128th St.
Kirkland, WA 98034

Evergreen Radia Imaging Center

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866.748.7226 (toll-free)
11521 NE 128th St., Suite 200
Kirkland, WA 98034



REDMOND

Evergreen Diagnostic Imaging, Redmond

425.895.4810
EvergreenHealth Medical Center - Redmond
8980 161st Ave. NE, Suite 340
Redmond, WA 98052