

# RADIOLOGY REFERRAL FORM - COMMON

## Appointment

Date: \_\_\_\_\_ Time: \_\_\_\_\_  Call patient to schedule  Patient will call to schedule

## Patient Information

Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.OB.: \_\_\_\_\_

Phone: \_\_\_\_\_ Interpreter Needed (language): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pregnant:  Yes  No Allergies: \_\_\_\_\_

## Clinic History (signs and symptoms REQUIRED)

Signs/Symptoms: \_\_\_\_\_

Duration: \_\_\_\_\_ Area: \_\_\_\_\_

Cause (Hx, Trauma, etc.): \_\_\_\_\_

Is this due to an injury?  Yes  No If yes, specify:  MVA  L&I  DOI: \_\_\_\_\_

## Prior Exams

Date: \_\_\_\_\_ Facility Location: \_\_\_\_\_

Date: \_\_\_\_\_ Facility Location: \_\_\_\_\_

## X-RAY

- Orbits for MRI clearance
- Sinus Limited (Waters)
- Sinus Complete
- Cervical Spine
- Shoulder L R Bi-lat
- Ribs L R Bi-lat
- Chest
- Chest Decub L R Bi-lat
- Thoracic Spine
- Abdomen
- Acute Abdomen Series
- Humerus L R Bi-lat
- Elbow L R Bi-lat
- Lumbar Spine
- Hip L R Bi-lat
- Bilateral Hips & Pelvis
- Ped Pelvis
- Pelvis only
- Pelvis w/Lateral Hip
- SI Joints
- Forearm L R Bi-lat
- Wrist L R Bi-lat
- Hand L R Bi-lat
- Finger L R Bi-lat
- Specify digit: \_\_\_\_\_
- Sacrum/Coccyx
- Scoliosis
- Femur L R Bi-lat
- Knee L R Bi-lat
- Tib/Fib L R Bi-lat
- Ankle L R Bi-lat
- Calcaneous (heel) L R Bi-lat
- Foot L R Bi-lat
- Toe L R Bi-lat
- Specify digit: \_\_\_\_\_
- Other: \_\_\_\_\_

## FLUOROSCOPY

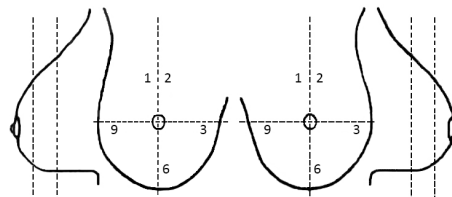
- HSG
- Esophagram
- Upper GI Series
- Cystogram
- Other: \_\_\_\_\_

## BONE DENSITOMETRY (DEXA)

- Pediatric DEXA
- Spine and Femur
- Vertebral Fracture Assessment
- Other: \_\_\_\_\_

## BREAST IMAGING

- Date of last mammogram: \_\_\_\_\_
- Breast Ultrasound: R/L/Bilat
  - Breast MRI with/without contrast
  - Breast MRI without contrast
  - Cyst Aspiration
  - Diagnostic Mammography (symptomatic)
    - Uni  Bi-lat
  - Galactogram: R/L
  - Screening Mammography (asymptomatic)
    - Uni  Bi-lat
  - Stereotactic Biopsy: R/L
  - US-Guided Biopsy: R/L
  - Wire Localization: R/L



Document Palp Abn: \_\_\_\_\_  
O'clock: \_\_\_\_\_ N+: \_\_\_\_\_

## Report

Call STAT: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax STAT: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax Routine: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Additional Report to: \_\_\_\_\_

## Images

- CD ROM
- Web PACS
- PACS
- Deliver to my office
- Send with patient

## Insurance Information (Send copy of patient's insurance card when faxing this referral)

Insurance(s): \_\_\_\_\_

Claim # (if applicable): \_\_\_\_\_

Pre-Authorization #: \_\_\_\_\_

## ULTRASOUND

- Thyroid/Neck
- Abdomen- Complete
  - Elastography
- Abdomen- Limited: \_\_\_\_\_
- Renal
- AAA Screen (Medicare only- once a lifetime)
- AAA follow-up (retroperitoneal, limited)
- Appendix
- Pelvic (transabdominal and/or transvaginal as needed for diagnostic visualization)
- Hysterosonogram
- Bladder Post-Void Residual
- Testicular/Scrotal
- Hernia, location: \_\_\_\_\_
- Extremity non-vascular: \_\_\_\_\_
- OB LMP/EDD: \_\_\_\_\_
  - Multiple  High Risk
  - < 14 weeks complete (TV as needed for visualization)
  - > 14 weeks complete (TV as needed for visualization)
  - Follow-up EFW
  - Umbilical Cord Doppler if indicated
- OB Biophysical Profile
- OB Limited (AFI, Position, previous anatomy not seen)
- Infant
  - Head  Hip  Spine  Pylorus
- Carotid Duplex Doppler
- Renal Artery Duplex
- Duplex Upper Extremity Veins: Bilat/R/L
- Duplex Lower Extremity: Arteries/Veins/R/L/Bilat
- Duplex Lower Extremity Varicose Veins: R/L/Bilat
- Duplex Doppler Vascular Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Referring Provider Signature (Required for exam) \_\_\_\_\_

## LOCATIONS

### BONNEY LAKE IMAGING CENTER

21110 SR 410 E Ste 110, Bonney Lake WA 98391



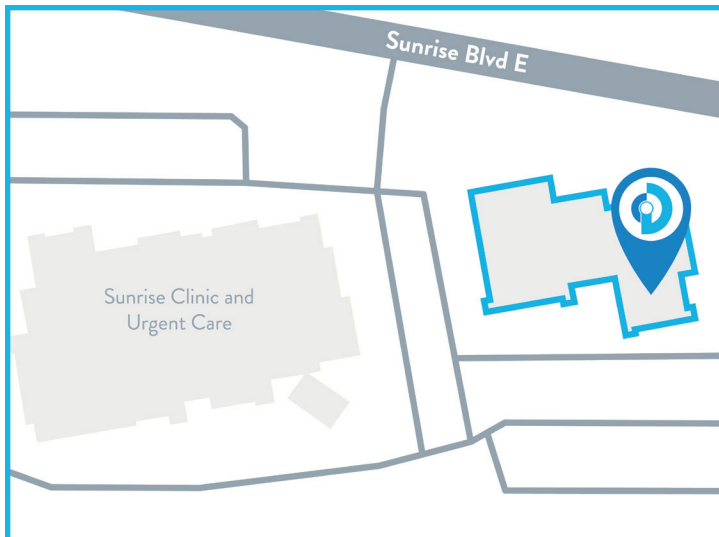
### PUYALLUP IMAGING CENTER

222 15th Ave SE, Puyallup WA 98372



### SUNRISE IMAGING CENTER

11212 Sunrise Blvd Ste 200, Puyallup WA 98374



## EXAM PREPARATIONS

### BONE DENSITOMETRY (DEXA)

- No preparation.

### FLUOROSCOPY

- HSG:** Exam must be performed within 3-5 days of the last day of your menstrual cycle; abstain from sexual intercourse starting the first day of your menstrual cycle until otherwise directed by your physician; if you think you might be pregnant, it is important that you tell us before your exam.

### ULTRASOUND - US

- Abdominal Exam:** *Night before:* Fat-free dinner; non-fat liquids permitted until 6 hours prior to exam, then nothing by mouth.
- Kidney, Renal, and Renal Artery:** *One hour prior to your exam:* Empty your bladder; drink 16 ounces of water; do not empty your bladder.

### ULTRASOUND - OB

- Less than 14 weeks:** *One hour prior to your exam:* Empty your bladder; drink 32 ounces of water; do not empty your bladder.
- More than 14 weeks:** Do not empty your bladder for 1 hour prior to your appointment.
- Pelvic and/or Trans Vaginal:** *One hour prior to your exam:* Empty your bladder; drink 32 ounces of water; do not empty your bladder.

### BREAST IMAGING

- Do not wear powder, deodorant, or lotion to exam.

### X-RAY

- No preparation.

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