Scheduling Phone: (360)794-1497 (7:30-4:00)

MRI, CT, US Fax: (360)794-1416 X-Ray Fax: (360)794-1423 Radiology Phone: (360)794-1409 Mammography Phone: (360)863-4654 Mammography Fax: (360)805-3474

□ Call patient to schedule □ Patient will call □ Confirm that order has been received by: □ Fax □ Phone PATIENT INFORMATION Patient Name: \_\_\_ Date of Birth: First MI Patient Phone: Home Cell\_\_\_ Work EXAM REQUESTED/REASON FOR EXAMS/SYMPTOMS/SPECIFIC AREA OF INTEREST Insurance: \_\_\_\_\_ Auth/Claim#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ ICD-10 Codes: □ X-Ray of \_\_\_\_\_ ☐ Ultrasound \_\_\_\_\_ □ CT □ MRI ☐ Bone Densitometry (DEXA) □ Mammography \_\_\_\_\_ ☐ Barium Studies \_\_\_\_\_ □ Arthrogram \_\_\_\_\_ ☐ Myelogram ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Interventional Radiology \_\_\_\_\_ □ Other RECENT LAB WORK Answer questions in this box for CT and/or MRI with contrast. A creatinine within 21 days is required. IV Contrast? ☐ Yes ☐ No ☐ PRN Creatinine: \_\_\_\_\_ Date: \_\_\_\_\_ Previous Contrast Reaction? ☐ Yes ☐ No. Does patient have: Anuerysm clip? Metal in eyes: Pacemaker? Other implanted electronic devices? Drug Allergies? ☐ Yes ☐ No ☐ NKDA ☐ Yes ☐ No Specify: \_\_\_\_\_ Is patient claustrophobic? ☐ Yes ☐ No REPORT/FILM/CD REQUEST □ Routine □ Call Report # \_\_\_\_ □ Call Report/Patient Wait □ Patient to return with CD □ **STAT** □ Fax Report # \_\_\_\_\_ □ Other \_\_\_ REFERRING DOCTOR Name: Phone: Date of next appt with referring Dr.: \_\_\_\_\_\_ Signature: \_\_\_\_\_ (Signature Required) **IMAGING EXAM REQUEST** F.O. BOX 646 14701 179 th AVENUE S.E. MONROE, WA 98272-0646 (360) 794-7497