

Please bring this referral form with you to your appointment

21700 Highway 99
Edmonds, WA 98026-8034

Scheduling Phone: (425) 640-4942
Scheduling Fax: (425) 670-8690

Phone: 425-640-4949
Fax: 425-640-4940

Patient Information

Patient Name: _____ Age: _____ Date of Birth: _____
Last First MI
 Patient Phone: (Home) _____ (Work/Cell) _____ Male Female
 Today's Date: _____ Appt Date: _____ Appt Time _____ Arrival Time: _____

Insurance: _____

Referring Provider

Name (Please print): _____
 Signature: _____

Optional Requests:

(Note: Reports are automatically faxed to referring physician)

- Call report
- Call report while patient waits
- STAT** CC: _____

Reason for Exam/Clinical History:

BUN results _____ Creatinine results _____
 Patient Pregnant? Yes No

<input type="checkbox"/> MRI Exam Requested <input type="checkbox"/> with contrast <input type="checkbox"/> without	<input type="checkbox"/> CT Exam Requested <input type="checkbox"/> with contrast <input type="checkbox"/> without
<input type="checkbox"/> Brain <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> MRA of Brain Specify: _____ <input type="checkbox"/> C-Spine _____ <input type="checkbox"/> T-Spine _____ <input type="checkbox"/> L-Spine <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left Specify: _____ <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Arthrogram <input type="checkbox"/> Other MRI: <input type="checkbox"/> BUN & Creatinine Test	<input type="checkbox"/> CTA <input type="checkbox"/> Brain <input type="checkbox"/> CT KUB <input type="checkbox"/> CT IVP <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Other CT: <input type="checkbox"/> BUN & Creatinine Test

Exams in red include 3D reconstruction

- C-Spine
- T-Spine
- L-Spine
- Maxillofacial
 - Mandible Maxilla
- Extremity
 - Upper Lower
 - Right Left
 Specify: _____

Breast MRI Exam Requested

<input type="checkbox"/> MRI Breast w/contrast (Known Breast Cancer) <input type="checkbox"/> MRI Guided Breast Biopsy <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> MRI Guided Wire Localization <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> BUN & Creatinine Test	<input type="checkbox"/> MRI Breast w/contrast & MRI Chest w/o contrast (Breast Screening) <input type="checkbox"/> BUN & Creatinine Test
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ULTRASOUND Exam Requested

<input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Thyroid <input type="checkbox"/> Venous Doppler Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pelvic <input type="checkbox"/> Scrotum <input type="checkbox"/> Other:	Abdomen <input type="checkbox"/> Complete <input type="checkbox"/> Gallbladder <input type="checkbox"/> Renal <input type="checkbox"/> RUQ, i.e., attn: liver	Obstetrics <input type="checkbox"/> < 14 weeks <input type="checkbox"/> > 14 weeks <input type="checkbox"/> FAS Fetal Anatomic Screening <input type="checkbox"/> Follow-up only indication _____
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DXA

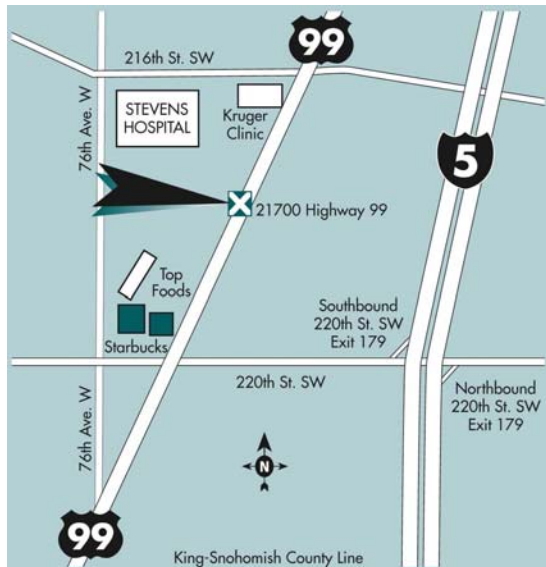
- Bone Density Test
- Vertebral Fracture Assessment
- Body Fat Test

X-RAY

<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Extremity: _____ <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wt bearing	<input type="checkbox"/> Chest <input type="checkbox"/> KUB <input type="checkbox"/> Other:
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Radia Imaging Centers are comprehensive state-of-the-art diagnostic imaging centers; part of the largest private radiology practice in the Pacific Northwest. They are full-service, outpatient centers offering patients convenient scheduling, easy access, free parking and a comfortable environment, as well as the advanced technology required for accurate evaluations and diagnoses. Our dedicated, experienced staff treats every patient with respect and dignity. For physicians, we provide fast, efficient results reporting, electronic hospital interface for retrieving patient history and images, and access to more than 60 board-certified radiologists.

For your convenience, Radia Imaging Centers accept most insurance plans. If you are unsure about your coverage, please contact your benefit administrator. We offer convenient appointments, including same day scheduling for some exams.



Stevens Radia
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HOURS:

MRI Scans	7:30 am - 8:30 pm
CT Scans	8:00 am - 5:30 pm
Ultrasound	7:00 am - 7:45 pm
Dexa (bone density)	8:30 am - 4:30 pm
X-Rays (walk-in) Mon- Fri	8:30 am - 5:00 pm
Saturday Hours	8:00 am - 4:30 pm

Patient Information

Please arrive 15 minutes before your exam and bring this referral form. We require 24-hours notice for cancellations.

Patient Instructions

Patients with other special needs (diabetes, renal impairment, claustrophobia, inability to lie still, wheelchair bound, etc.), should call in advance of appointment.

MRI

Please notify the MRI facility for further instructions if:

- You are pregnant, or could be pregnant*
- You have a pacemaker or heart valve*
- You have a history of metal in the eyes*
- You have an aneurysm clip in the brain*
- You have any tattoos; including permanent eyeliner*

Please wear comfortable clothing. You may be asked to change into metal-free clothing.

Although you may be given an MRI contrast injection during the exam, there are no food restrictions prior to arrival.

Please check with your doctor for any medication directions.

CONTRAINDICATIONS include but are not limited to, the presence of cardiac pacemakers, ferromagnetic intracranial aneurysm clips, neurostimulators, cochlear implants, and certain other ferromagnetic foreign bodies in critical locations.

CT Scan

No solid foods or drink 3 hours prior to your scheduled exam time. You should take your daily medications with sips of water or juice.