Patient Centered Imaging & Technology Solutions

RADIA®

ROCKWOOD HEALTH SYSTEM®

Deaconess Hospital | Rockwood | Valley Hospital

PODIATRY IMAGING STUDY ORDER FORM

Patient Name: _____ ☐ Male ☐ Female DOB: _____

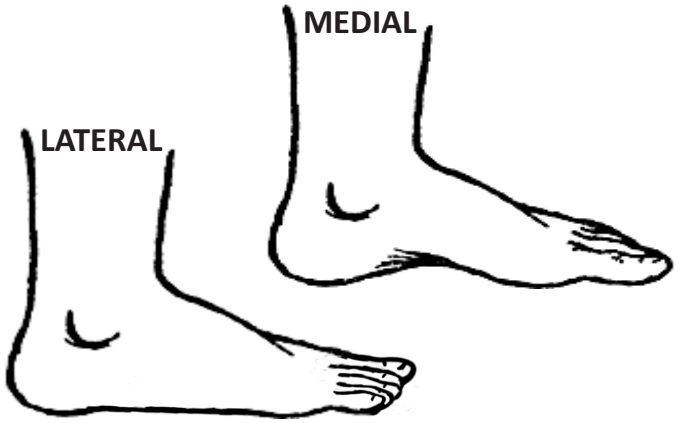
Phone: _____ /H _____ /C Previous Studies? ☐ No ☐ Yes Facility: _____

Insurance: _____ Auth Initiated? ☐ No ☐ Yes Auth #: _____

1. *CHOOSE EXAM TYPE*

CT:	☐ With Contrast ☐ W/O Contrast ☐ Contrast at Radiologist Discretion ☐ 3D Reformats
MRI:	☐ With Contrast ☐ W/O Contrast ☐ Contrast at Radiologist Discretion ☐ 3T Requested (Deaconess only) ☐ T2 Mapping (Deaconess only)
Ultrasound:	☐ LE Arterial Study ☐ LE Venous Study ☐ MSK (RWC Main Clinic only) ☐ Other: _____
X-Ray:	☐ Toes ☐ Foot ☐ Ankle ☐ Calcaneus ☐ Tibia/Fibula ☐ Other (Mark Below)

2. *DRAW/SELECT AREAS OF INTEREST*



Area of Interest:

All Exams: ☐ Right ☐ Left ☐ Bilateral

MRI/CT: ☐ Forefoot/Toes ☐ Midfoot ☐ Ankle/Hindfoot ☐ Calf ☐ Other: _____

MSK US: ☐ Forefoot/Toes ☐ Med Ankle ☐ Lat Ankle ☐ Ant Ankle ☐ Achilles/Calf ☐ Plantar Fascia ☐ Soft Tissue ☐ Other _____

Clinical Diagnosis & Symptoms: _____

3. *CHOOSE REPORT TYPE/METHOD OF DELIVERY*

☐ Routine	☐ Stat	☐ Copy Additional Provider	Name:
☐ Fax: _____	☐ Phone: _____	☐ Fax: _____	☐ Phone: _____
☐ Mail CD	☐ Send CD with Patient		

4. *ORDERING PROVIDER SIGNATURE:* _____ Date: _____

PLEASE PRINT NAME: _____ Phone: _____

5. *CHOOSE IMAGING FACILITY*

☐ **Call Patient to Schedule** ☐ **Patient Will Call to Schedule**

☐ Deaconess Hospital 3T ONLY 910 W. 5th Ave, Suite 150 Spokane, WA 99204 Ph: (509) 473-3320 Fax: (509) 473-3325	☐ Deaconess Hospital Xray, CT, 1.5 MRI 800 W. 5th Avenue Spokane, WA 99204 Ph: (509) 473-7147 Fax: (509) 473-7511	☐ Rockwood Clinic – Main Xray, CT, 1.5 MRI, U/S 400 E. 5th Avenue Spokane, WA 99204 Ph: (509) 838-2531 Fax: (509) 755-6580	☐ Valley Hospital Xray, CT, 1.5 MRI 12606 E. Mission Avenue Spokane Valley, WA 99216 Ph: (509) 473-5483 Fax: (509) 473-5490

Patient Screening Questions and Information

Does patient have any metal and/or implants in the body/head? (i.e. pacemaker, stents, clips, wires, IUD, replacements, etc.) ☐ Yes ☐ No

If yes, specify: _____

Is patient pregnant? ☐ Yes ☐ No

Is patient claustrophobic? ☐ Yes ☐ No If yes:

☐ Oral (Provider gives oral Rx to pt.)

☐ IV, Conscious sedation (driver needed)

☐ IV, General Anesthesia (driver needed)

Creatinine Requirements (MRI Contrast Only)
For patients requiring contrast and having any of the health concerns listed below, creatinine must be drawn within 6 weeks of the MRI exam.

☐ 60+ Years Old ☐ Hypertension
☐ Diabetes ☐ History of Renal Disease
☐ Liver Disease ☐ Current Chemo Patient

☐ Creatinine _____ ☐ Please Draw Creatinine