SWEDISH | HEALTH FOR GOOD

SWEDISH MEDICAL IMAGING

SWEDISH BALLARD IMAGING REQUISITION FORM

Phone: 206-781-6040 • Fax: 206-781-6154 • 5350 Tallman Ave. N.W., Seattle, WA 98107 **Today's date:** ______________

Patient information: *(All fields are required)*

Patient legal name: ______________________________ Date of birth: ______________

Patient phone number: ______________ ☐ Male ☐ Female ☐ Other: ________ Height: ________ Weight: ____

☐ Call patient to schedule ☐ Need interpreter (language): ______________ Need assistive: ☐ Hearing ☐ Visual device

Pregnant? ☐ Yes ☐ No **Diabetic?** ☐ Yes ☐ No **Allergies?** ☐ Contrast ☐ Iodine ☐ Latex ☐ Other: ____________

Insurance/Plan: ______________ Member #/ID: ______________ ☐ Uninsured ☐ Self-pay

Authorization #: ______________ Valid date(s): ______________ ☐ L & I, Claim #: ____________

Ordering provider: *(All fields are required)*

Physician printed name: ______________________ NPI: ______________ Phone: ______________

Signature: (required) ______________________ Date/Time: ______________________

Clinic contact: ______________________________________ Clinic fax: ______________

In event of critical finding, contact: ______________________________ Phone: ______________

Reason for exam: *(All fields are required)*

☐ ASAP ☐ Routine Symptoms/Diagnosis: ______________________________________

Reason for exam: ____

______________________ ICD-10: ______________________ CPT code(s): ______________________

Reports are always faxed. ☐ Fax ***additional*** report to: Dr. ______________________ Fax: ______________

Prior films? ☐ No ☐ Yes, where? ______________________ If injured, date of injury: ______________

Swedish Image Transfer Request Form: https://www.swedish.org/services/medical-imaging/image-transfer-request

Comments/Instructions: ____

Decision support Vendor (G code) __________ Adherence code (M modifier) ________ ID ______ Score ______

Exam ordered: *(Patient preps and directions on back)*

Does patient have any implants? ☐ No ☐ Yes, what and where ______________________________________

If ordering MR or CT: **IV contrast?** ☐ With ☐ Without ☐ Without and with **creatinine:** __________ Date: ______________

MRI

☐ Brain
☐ Soft tissue neck
Spine ☐ C ☐ T ☐ L
☐ Shoulder ☐ Hip
☐ Knee ☐ Ankle ☐ Foot
☐ Abd/Pelvis (screen)
☐ Female pelvis
☐ MSK pelvis
☐ Abdomen
☐ MR IVP (renal mass)
☐ MRCP (biliary) ☐ Adrenal
☐ Brain MRA
☐ Neck MRA (carotids)
☐ Chest MRA
☐ Pelvis MRA
☐ Extremity
☐ Right ☐ Left ☐ Arthrogram
Other MRI: ______________

CT

☐ Head
☐ Sinus
☐ Soft tissue neck
☐ Chest
☐ Abdomen ☐ Pelvis
Spine ☐ C ☐ T ☐ L
☐ Liver
☐ Pancreas
☐ Adrenal
☐ CT IVP (renal mass)
☐ CT KUB (renal stone)
☐ Head
☐ Neck CTA
☐ Pulmonary CTA (PE)
☐ CT aortogram
☐ Extremity
☐ Right ☐ Left ☐ Arthrogram
Other CT: ______________

Ultrasound

☐ Abd ☐ Limited ☐ Complete
☐ Pelvis ☐ W/TV ☐ W/O TV
☐ Kidney/Bladder
☐ Appendix
☐ Scrotum ☐ Aorta
☐ Thyroid ☐ Hernia
☐ Soft tissue mass: ________
Obstetric:
☐ Dating
☐ Fetal anatomy ☐ High risk
☐ Biophysical profile
☐ Growth
☐ Nuchal Trans *(attach lab slip if indicated)*
☐ *Other ultrasound:* ________

Breast Center

☐ Bone density

X-ray

☐ Sinus ☐ Chest
☐ Abdomen ☐ Pelvis
☐ Ribs
Spine ☐ C ☐ T ☐ L
☐ Sacrum/Coccyx
☐ Extremity
☐ Right ☐ Left ☐ Wt-bearing
☐ *Other X-ray:* ________

Fluoroscopy

☐ Barium swallow ☐ Modified
☐ Upper GI
☐ Small bowel FT
☐ Arthrogram
☐ Barium enema
☐ *Other fluoro:* ________

Please fax order to: 206-781-6154. ***Thank you for choosing Swedish!***

PATIENT INSTRUCTIONS

MRI

MRI scanners do not use radiation. Please arrive 15 minutes before your exam. Please remove all jewelry, watches, piercings, etc. You will be required to change into a hospital gown.

- For **abdominal exams:** Do not eat for 4 hours (clear non-carbonated liquids OK).

For all other exams, there are no eating or drinking restrictions.

Any medication for anxiety or claustrophobia must be pre-arranged by the patient's doctor and picked up prior to arrival. Since medications may cause drowsiness, patient must arrange for a ride to and from appointment.

If patient is diabetic, has renal disease, or over 60 years of age:
Creatinine: ____________________ Date: ______________________

Does patient have?

Pacemaker/Defibrillator	☐ Yes	☐ No
Ferromagnetic prosthesis	☐ Yes	☐ No
Ferromagnetic aneurysm clip	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Other implanted device	☐ Yes	☐ No
Metal anywhere in body	☐ Yes	☐ No
Tattoo/Body piercing	☐ Yes	☐ No
Ortho pins/Screws/Rods/Joints	☐ Yes	☐ No
Gadolinium?	☐ Yes	☐ No

CT

We use detailed protocols and other techniques to ensure your radiation dose is as small as possible.

Please arrive 15 minutes prior to your exam, unless otherwise instructed.

- For **thorax/chest:** Do not eat for 2 hours prior to exam. Can sip clear liquids.
- For **abdomen or pelvis:** Do not eat or drink for 4 hours prior to exam. If oral contrast is required, patient must arrive **one hour** prior to exam to receive contrast. If you have had a barium study within the last 3 weeks, please contact us prior to your exam.

If patient is diabetic, has renal disease, or over 60 years of age: Creatinine: ____________________ Date: ______________________

ULTRASOUND

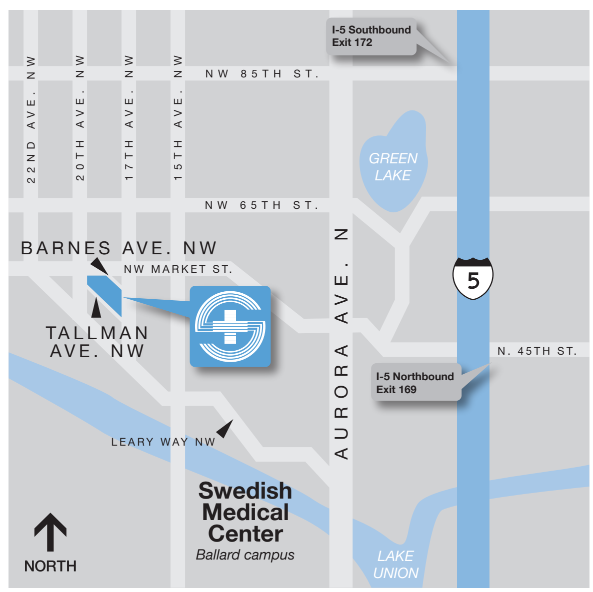
Please arrive 15 minutes before your exam.

- For **abdomen, gallbladder and liver studies:** Do not eat or drink for 8 hours prior to your exam.
- For **pelvis, kidney and OB studies:** Drink three 8 ounce glasses of water 1 hour before your exam and keep your bladder full.

X-RAY/FLUOROSCOPY

We accept walk-ins for most X-rays. However, the following fluoroscopic procedures must be scheduled; please arrive 15 minutes prior to scheduled time.

- For **esophagram, small bowel and upper GI:** Do not eat, drink, chew gum or smoke for 8 hours prior to appointment.
- For **barium enema:** A 24-hour full bowel prep is required. Pick up bowel prep at your physician's office or any retail pharmacy as instructed.



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swedish.org/services/medical-imaging