EVERGREEN RADIA IMAGING CENTER
Scheduling: 425-899-2831
Radia Fax: 425-952-6150
Radia Phone: 425-952-6100
www.radiax.com
(See reverse side for address, map and directions)

Please bring this referral form with you to your appointment

CHIROPRACTIC REQUEST FOR IMAGING

Scheduling: 425-899-2831
Fax: 425-899-2828
www.evergreenhealth.com/imaging
(See reverse side for address, map and directions)

Patient Information: Appt. Date: ____________ Appt. Time: ____________

Name: ______________________ (Last) (First) (MI) Age: ________ Date of Birth: ________

Home Phone: ____________ Work/Cell Phone: ____________ ❑ Male ❑ Female

Insurance: ____________

Referring Physician:

Name: ____________

Clinic: ____________

Fax: ____________

Physician Signature: ____________ Date: ________

Optional Requests:

❑ Call report
❑ Call report while patient waits
❑ Send CD with patient
❑ Send CD directly to referring physician
❑ Copy additional reports to:
Doctor: ____________
Clinic: ____________
Fax: ____________

Reason for Exam/Clinical History:
____
____
____
____
____

Exam Priority: ❑ Routine ❑ Urgent
Patient Pregnant: ❑ Yes ❑ No
Allergies: ____________
Patient Height: ________ Weight: ________
Relevant previous imaging studies? ❑ Yes ❑ No
If yes: ❑ Office will send ❑ Patient will bring

X-RAY

❑ Weight Bearing	❑ Cervical Spine	❑ Lumbar Spine	❑ Thoracic Spine	❑ Rib ❑ Left ❑ Right
❑ Hip ❑ Left ❑ Right	❑ 3V ❑ Pillar	❑ 3V	❑ 2-3V	❑ Other: ________
Extremity: ❑ Left ❑ Right	❑ 5V Obliques	❑ 5V Obliques	❑ CT view/Swimmers	________
________	❑ 5V Flex Ext	❑ 5V Flex Ext		________
❑ Leg Length Study	❑ 7V	❑ Bi-Lat Bend		________

MRI

❑ Shoulder ❑ Left ❑ Right ❑ Arthrogram
❑ Hip ❑ Left ❑ Right ❑ Arthrogram
❑ Knee ❑ Left ❑ Right ❑ Arthrogram
❑ Ankle ❑ Left ❑ Right
❑ Foot ❑ Left ❑ Right
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ Pelvis
❑ Lumbar Sacral Plexus
❑ Carotid MRA
❑ Pars/spondylosis (3T only)
❑ Other MRI: ________

IV Contrast? ❑ PRN ❑ Yes ❑ No
BUN and Creatinine within one month is required if patient has:
Diabetes? ❑ Yes ❑ No
Renal disease? ❑ Yes ❑ No
Age > 60? ❑ Yes ❑ No
BUN: ______ Creatinine: ______
Date: ____________

Does patient have:
Aneurysm Clip? ❑ Yes ❑ No
Metal in eyes? ❑ Yes ❑ No
Claustrophobia? ❑ Yes ❑ No
Pacemaker? ❑ Yes ❑ No
Other implanted electronic device? ❑ Yes ❑ No
____

CT

❑ Head
❑ Sinus
❑ Soft Tissue Neck
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ Myelogram
❑ Other CT: ________
____

IV Contrast? ❑ Yes ❑ No
BUN and Creatinine within one month is required if patient has:
Diabetes? ❑ Yes ❑ No
Renal disease? ❑ Yes ❑ No
Age > 60? ❑ Yes ❑ No
BUN: ______ Creatinine: ______
Date: ____________

PAIN INJECTIONS

❑ Epidural Steroid Inj. (ESI)
❑ Facet Injection
❑ Select Nerve Root Block
❑ Median Branch Block
❑ Joint Pain/Steroid Inj.
____
____

ULTRASOUND

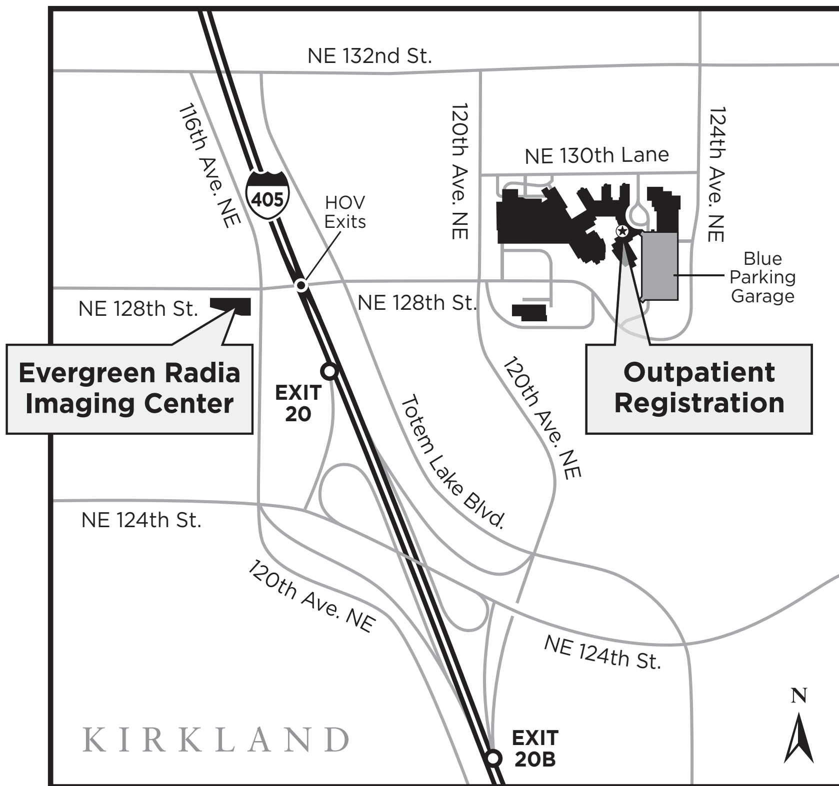
Specify: ____________
____

DEXA

❑ Bone Density

(6/15)

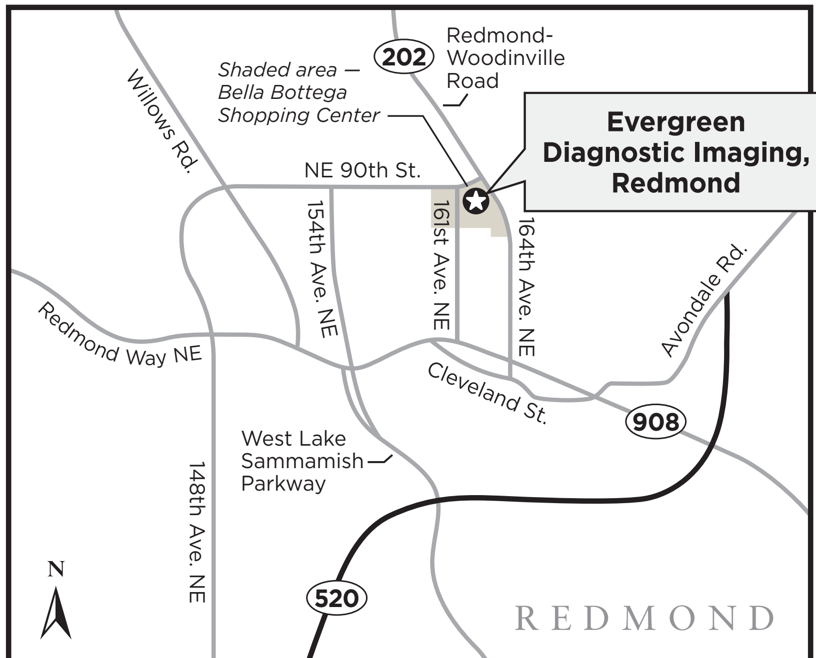
Diagnostic Imaging Locations



KIRKLAND

EvergreenHealth Medical Center Diagnostic Imaging
425.899.2831
12040 NE 128th St.
Kirkland, WA 98034

Evergreen Radia Imaging Center
425.952.6100
866.748.7226 (toll-free)
11521 NE 128th St., Suite 200
Kirkland, WA 98034



REDMOND

Evergreen Diagnostic Imaging, Redmond
425.895.4810
EvergreenHealth Medical Center – Redmond
8980 161st Ave. NE, Suite 340
Redmond, WA 98052

EvergreenHealth