Diagnostic Imaging | Phone: 206.860.5496 • Fax: 206.320.6711

Exam/Procedure Order Form

THE POLYCLINIC

LAST		FIRST	
Cell/Home Phone	Work Phone	DOB	MRN#
Weight/Height	Allergies	Pregnant ❑ YES ❑ NO	
Type of Exam: Reason for Exam:			

EXAM

		CPT Code(s)
❑	MRI	
❑	CT	
❑	X-ray	
❑	Ultrasound	
❑	Nuc Med (non-cardiac)	
❑	Mammography	
❑	Fluoroscopy	
❑	Bone density	
❑	Other:	
		❑ Left ❑ Right

CONTRAST

❑	With
❑	Without
❑	With and Without
❑	As indicated by radiologist

CONTRAST INFORMATION

If allergic to contrast or iodine, patient will need pre-exam / procedure prep.

Call 206.860.5496

Will need Creatinine (<30 days) IF:

❑	Diabetic
❑	Kidney disease
❑	>60 years old
❑	Chemotherapy in past 30 days
❑	Multiple myeloma or other hyperproteinemia
❑	Myocardial dysfunction w/renal hypo perfusion

Creatinine Level:

Date Drawn:

PRIOR / COMPARISON

❑	Please list date and facility if there are any relevant prior imaging studies

DIAGNOSIS CODE(S)

❑	
❑	
❑	

Authorization is required prior to scheduling for all CT, MRI, and Nuclear Medicine.

AUTHORIZATION NUMBER:_____

AUTHORIZATION DATES:_____ to _____

CLINICAL DECISION SUPPORT

Decision Support Number is now required prior to scheduling for all CT, MRI and Nuclear Medicine Exams.

Decision Support Number _____

Decision Support Vendor _____

Decision Support Score _____

REPORT/IMAGE REQUEST

❑	Routine	
❑	Urgent (<2 hour report)	
❑	Stat (<30 minute report)	
❑	Stat Call report	Phone:
❑	Give patient CD	
❑	Patient to wait until report is called/patient back to office	

REFERRING PROVIDER/NPI

Name

Specialty

Phone

Physician signature

NPI#

Please have patient call our scheduling line if they have not received a phone call after 48 hours of submitting this order.