Diagnostic Imaging
Exam/Procedure Order Form
Phone: 206.860.5496 • Fax: 206.320.6711

LAST
FIRST

Cell/Home Phone Work Phone DOB MRN#

Weight/Height Allergies Pregnant  □ YES □ NO

EXAM

DX Code: Description

☐ 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:

INDICATION/CLINICAL DATA

☐
☐
☐

Authorization required prior to scheduling for all CT and MRI studies by Referring office:

Authorization number:
Authorization date:

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#