Radiology for Outpatient Services

Fax orders to 360-496-3508 Scheduling 360-496-3523

PATIENT INFORMATION	
Patient Name:	
DOB:	
Insurance/ Authorization #:	
Diagnosis:	
Physician Signature	**Physician Fax**:

Can we modify orders ☐Yes/☐No Contact MD #_____

CT (PLEASE SPECIFY CONTRAST)			IFORDERING CONTRAST AND PATIENT IS 65 OR DM PLEASE SEND CURRENT LABS LAST 30 DAY OR SEND AN ORDER.
☐	Abdomen☐w or ☐wo	☐Pelvic☐w or ☐wo	☐ CTA (are) _____ ☐ CT Low Dose lung Screening
☐	Chest ☐w or ☐wo	☐Head/ Brain☐w or ☐wo	☐ Extremity Upper (R/L)☐w or ☐wo☐ Other _____
☐	Chest, Abdomen, Pelvic ☐w or ☐wo		☐Extremity Lower (R/L) ☐w or ☐wo
☐	Abdomen, Pelvic ☐w or ☐wo		☐ Neck Soft Tissue ☐w or ☐wo
ULTRASOUND			
☐	Abdomen Comp	☐ Abdomen Limited	☐ Pregnant ☐ Other _____
☐	Ankle	☐ Aorta	☐ Renal
☐	Bladder	☐ Carotid	☐ Retroperitoneal
☐	Duplex Hemodialysis	☐ Echo	☐Scrotum
☐	Extremity	☐ LE	☐ Thyroid
☐	Neck	☐ Pelvis	☐ UE
MAMMO			**WHERE AND WHEN WAS THE LAST MAMMOGRAM**
☐	Bilateral Mammo Screening		
☐			

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MRI (PLEASE SPECIFY CONTRAST)			IF PATIENT IS 60 OR DM PLEASE SEND CURRENT LABS LAST 30 DAYS OR SEND AN ORDER
☐	Abdomen ☐w or☐wo ☐Brain ☐w or ☐wo		☐Pelvis ☐w or☐wo ☐TMJ ☐w or ☐wo
☐	Chest ☐w or☐wo	☐ Face/ Neck ☐w or ☐wo	☐ Cervical Spine☐w or☐wo ☐Lumbar Spine ☐w or ☐wo ☐Thoracic Spine☐w or☐wo
☐	LE joint☐w or☐wo☐ LE non-Joint☐w or☐wo		☐ UE Joint w or wo ☐ UE non-Joint ☐w or☐wo
NUCLEAR MEDICINE			
☐	Cardiac Stress ☐ Hida Scan		☐ Thyroid ☐ Other _____
XRAY (PLEASE SPECIFIY HOW MANY VIEWS)			
☐	Abdomen _____ ☐ AC Joint _____		☐ Ankle _____ ☐ Bone _____ ☐ Chest _____
☐	Cholangiography ____ ☐ Clavicle _____		☐ Elbow _____ ☐ Eye _____ ☐ Facial Bones _____
☐	Femur _____ ☐ Fingers_____		☐ Foot _____ ☐ Forearm_____ ☐ GI Tube Inj _____
☐	Hand _____ ☐ Heel _____ ☐Hip_____		☐ Humerus_____ ☐ Knee _____ ☐ LE Infant _____
☐	Mandible _____☐ Nasal Bones _____		☐ Neck soft tissue _____ ☐ Nose to Rectum _____
☐	Optic _____☐ Orbits Comp _____		☐ Pelvis _____ ☐ Pelvis & Hip _____ ☐ Ribs _____
☐	Sacrum /Coccyx _____ ☐ Scapula_____		☐ Shoulder _____ ☐ Shoulder Comp _____
☐	SI Joints _____ ☐ Sinuses _____		☐ Skull _____ ☐ C Spine _____ ☐ L Spine _____
☐	T Spine _____ ☐ Thoracolumbar Spine		☐ Sternoclavicular ____ ☐ Sternum _____
☐	Tibia + Fibula ____☐Bil☐Lt☐Rt		☐ TMJ_____ ☐ Toe ____ ☐ UE Infant _____
☐	Urethrocystography Voiding		☐ Wrist Comp _____☐Bil ☐Lt ☐Rt☐ Other_____

Comments/ History:_____