



Fax to (206) 987-2730
Scheduling Telephone (206) 987-2089

- Contact patient to schedule. Patient will call to schedule.
 Radiology exam scheduled, faxed for documentation only. Date and time of appointment:

Today's date:		MRN:	
Last Name:	First:	M.I.:	
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Parent/Guardian Name:			
Best Contact Phone: ()		Interpreter Needed <input type="checkbox"/> Language:	

Please check if a CD of radiology images is to be sent with the patient

CT **NM** **US** **DX** **MRI** (see MRI questions below) **IR** (call 987-4599 to schedule)

Exam Requested:

Diagnosis:

ICD9 Code:

- Sedation needed** **Labs:**
 Contrast needed **Allergies:**

Please consider when ordering exams for female patients 11 years and older that radiation can be harmful to the patient and fetus. Start date of last menstrual period:

Relevant History of Present Illness/Complaint:

MRI specific questions:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Orthodontia (Braces) | <input type="checkbox"/> Previous Surgery, Date/Location: |
| <input type="checkbox"/> Aneurysm clips | <input type="checkbox"/> Implant | <input type="checkbox"/> Previous MR, Date/Location: |
| <input type="checkbox"/> Metal Fragments | <input type="checkbox"/> Sedation needed | <input type="checkbox"/> Neurostimulator Type: |

Referring Physician (include first and last name, please print

Referring Physician signature:

Best contact number for critical findings: () **Fax Number:** () -

Please send an additional report to
(Physician's first and last name): **Fax Number:** () -

NOTE: Group Health, Molina, Tricare and other insurance subscribers may require pre-authorization prior to scheduling.

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