

RADIOLOGY REFERRAL FORM - COMMON



Appointment

Date: _____ Time: _____ ☐ Call patient to schedule ☐ Patient will call to schedule

Patient Information

Date: _____ Referring Provider: _____

Patient Name: _____ D.OB.: _____

Phone: _____ Interpreter Needed (language): _____

Height: _____ Weight: _____ Pregnant: ☐ Yes ☐ No Allergies: _____

Clinic History (signs and symptoms REQUIRED)

Signs/Symptoms: _____

Duration: _____ Area: _____

Cause (Hx, Trauma, etc.): _____

Is this due to an injury? ☐ Yes ☐ No If yes, specify: ☐ MVA ☐ L&I ☐ DOI: _____

Prior Exams

Date: _____ Facility Location: _____

Date: _____ Facility Location: _____

X-RAY

- ☐ Orbits for MRI clearance
- ☐ Sinus Limited (Waters)
- ☐ Sinus Complete
- ☐ Cervical Spine
- ☐ Shoulder L R Bi-lat
- ☐ Ribs L R Bi-lat
- ☐ Chest
- ☐ Chest Decub L R Bi-lat
- ☐ Thoracic Spine
- ☐ Abdomen
- ☐ Acute Abdomen Series
- ☐ Humerous L R Bi-lat
- ☐ Elbow L R Bi-lat
- ☐ Lumbar Spine
- ☐ Hip L R Bi-lat
- ☐ Bilateral Hips & Pelvis
- ☐ Ped Pelvis
- ☐ Pelvis only
- ☐ Pelvis w/Lateral Hip
- ☐ SI Joints
- ☐ Forearm L R Bi-lat
- ☐ Wrist L R Bi-lat
- ☐ Hand L R Bi-lat
- ☐ Finger L R Bi-lat
- Specify digit: _____
- ☐ Sacrum/Coccyx
- ☐ Scoliosis
- ☐ Femur L R Bi-lat
- ☐ Knee L R Bi-lat
- ☐ Tib/Fib L R Bi-lat
- ☐ Ankle L R Bi-lat
- ☐ Calcaneus (heel) L R Bi-lat
- ☐ Foot L R Bi-lat
- ☐ Toe L R Bi-lat
- Specify digit: _____
- ☐ Other: _____

FLUOROSCOPY

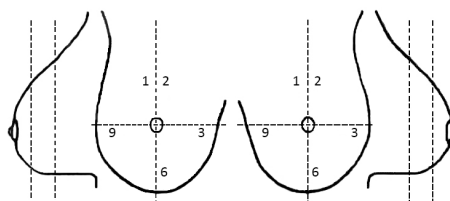
- ☐ Esophagram
- ☐ Upper GI Series
- ☐ Cystogram
- ☐ Other: _____

BONE DENSITOMETRY (DEXA)

- ☐ Pediatric DEXA
- ☐ Spine and Femur
- ☐ Vertebral Fracture Assessment
- ☐ Other: _____

BREAST IMAGING

- Date of last mammogram: _____
- ☐ Breast Ultrasound: R/L/Bilat
- ☐ Breast MRI with/without contrast
- ☐ Breast MRI without contrast
- ☐ Cyst Aspiration
- ☐ Diagnostic Mammography (symptomatic)
 - ☐ Uni ☐ Bi-lat
- ☐ Screening Mammography (asymptomatic)
 - ☐ Uni ☐ Bi-lat
- ☐ Stereotactic Biopsy: R/L
- ☐ US-Guided Biopsy: R/L
- ☐ Wire Localization: R/L



Document Palp Abn: _____

O'clock: _____ N+: _____

Report

Call STAT: (_____) _____ - _____

Fax STAT: (_____) _____ - _____

Fax Routine: (_____) _____ - _____

Additional Report to: _____

Images

- ☐ CD ROM
- ☐ Web PACS
- ☐ PACS
- ☐ Deliver to my office
- ☐ Send with patient

Insurance Information (Send copy of patient's insurance card when faxing this referral)

Insurance(s): _____

Claim # (if applicable): _____

Pre-Authorization #: _____

ULTRASOUND

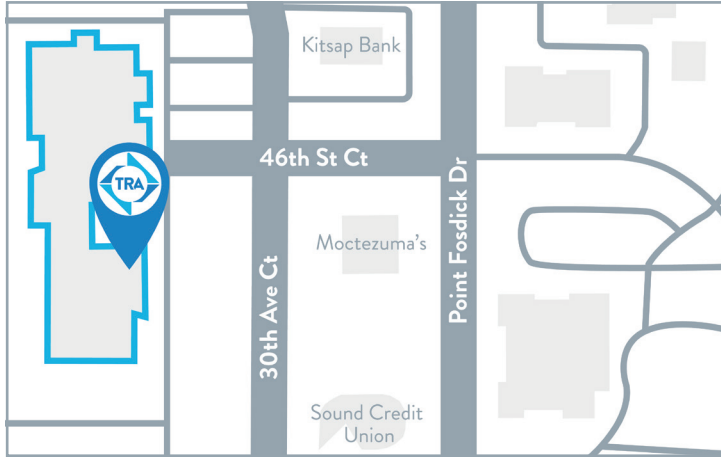
- ☐ Thyroid/Neck
- ☐ Abdomen- Complete
 - ☐ Elastography
- ☐ Abdomen- Limited: _____
- ☐ Renal
- ☐ AAA Screen (Medicare only- once a lifetime)
- ☐ AAA follow-up (retroperitoneal, limited)
- ☐ Appendix
- ☐ Pelvic (transabdominal and/or transvaginal as needed for diagnostic visualization)
- ☐ Bladder Post-Void Residual
- ☐ Testicular/Scrotal
- ☐ Hernia, location: _____
- ☐ Extremity non-vascular: _____
- ☐ OB LMP/EDD: _____
 - ☐ Multiple ☐ High Risk
 - ☐ < 14 weeks complete (TV as needed for visualization)
 - ☐ > 14 weeks complete (TV as needed for visualization)
 - ☐ Follow-up EFW
 - ☐ Umbilical Cord Doppler if indicated
- ☐ OB Biophysical Profile
- ☐ OB Limited (AFI, Position, previous anatomy not seen)
- ☐ Infant
 - ☐ Head ☐ Hip ☐ Spine ☐ Pylorus
- ☐ Carotid Duplex Doppler
- ☐ Renal Artery Duplex
- ☐ Duplex Upper Extremity Veins: Bilat/R/L
- ☐ Duplex Lower Extremity:
 - Arteries/Veins/R/L/Bilat
- ☐ Duplex Lower Extremity Varicose Veins:
 - R/L/Bilat
- ☐ Duplex Doppler Vascular Other: _____
- ☐ Other: _____

Referring Provider Signature (Required for exam) _____

LOCATIONS

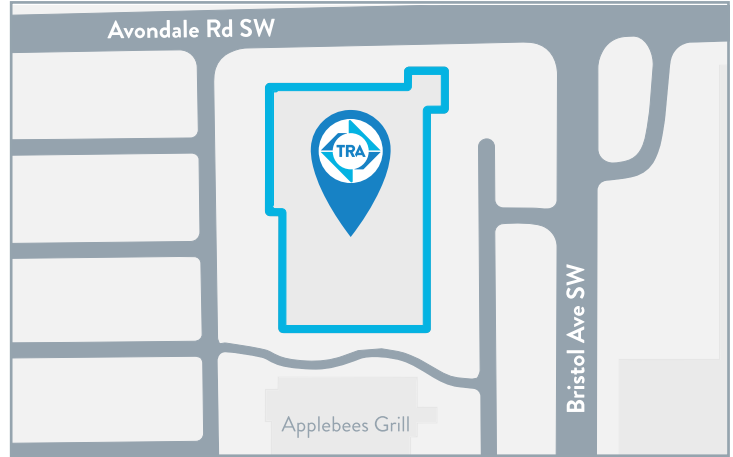
❑ TRA GIG HARBOR

4700 Point Fosdick Dr NW Ste 110, Gig Harbor WA 98335



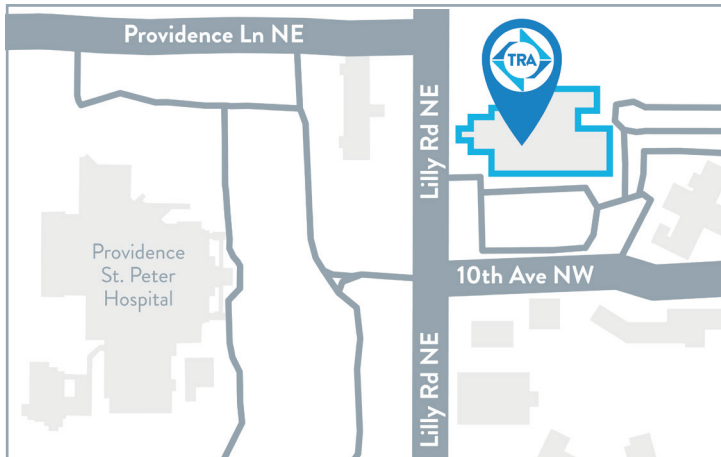
❑ TRA LAKEWOOD

10321 Gravelly Lake Dr SW Ste E, Lakewood, WA 98499



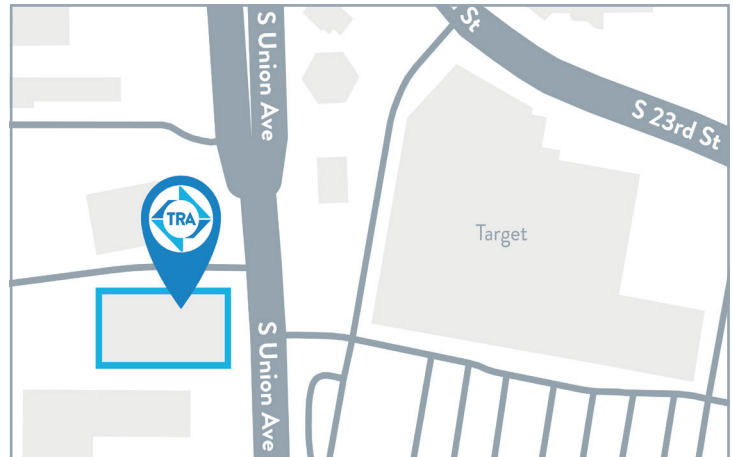
❑ TRA OLYMPIA - ON LILLY

500 Lilly Rd NE Ste 160, Olympia WA 98506



❑ TRA TACOMA - ON UNION

2502 S Union Avenue, Tacoma WA 98405



EXAM PREPARATIONS

BONE DENSITOMETRY (DEXA)

- ❑ No preparation.

BREAST IMAGING

- ❑ Do not wear powder, deodorant, or lotion to exam.

FLUOROSCOPY

- ❑ **HSG:** Exam must be performed within 3-5 days of the last day of your menstrual cycle; abstain from sexual intercourse starting the first day of your menstrual cycle until otherwise directed by your physician; if you think you might be pregnant, it is important that you tell us before your exam.

ULTRASOUND - OB

- ❑ **Less than 14 weeks:** *One hour prior to your exam:* Empty your bladder; drink 32 ounces of water; do not empty your bladder.
- ❑ **More than 14 weeks:** Do not empty your bladder for 1 hour prior to your appointment.
- ❑ **Pelvic and/or Trans Vaginal:** *One hour prior to your exam:* Empty your bladder; drink 32 ounces of water; do not empty your bladder.

ULTRASOUND - US

- ❑ **Abdominal Exam:** *Night before:* Fat-free dinner; non-fat liquids permitted until 6 hours prior to exam, then nothing by mouth.
- ❑ **Kidney, Renal, and Renal Artery:** *One hour prior to your exam:* Empty your bladder; drink 16 ounces of water; do not empty your bladder.

X-RAY

- ❑ No preparation.