

This form is part of the patient's medical record and must be completed for referral



Date of Referral _____ Referring Provider Name _____

Patient Name (first, MI, last) _____

Patient Phone (____) _____ (home) (____) _____ (work or cell)

D.O.B. _____ SS# _____

Written Diagnosis/Reason/Symptom for Exam(s) **REQUIRED**

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. Rule out, Possible or Probable Conditions cannot be coded. For Medicare Policy information see the Part B Bulletin or www.noridian.com/medweb

Notes: Height _____ Weight _____ Allergies _____

BUN/Creatinine _____ / _____ (date drawn) _____ / _____ / _____

PRIOR EXAMS:

Date of Service _____

Facility Location _____

33915 1st Way S, Suite 130 Federal Way, WA 98003

Scheduling Phone: 253-815-1231 Fax: 253-815-1225

www.medicalimagingon1st.com

Appointments:

Exam _____

M T W Th F S Sn

Date _____ - _____ - _____

Time _____ : _____

Exam _____

M T W Th F S Sn

Date _____ - _____ - _____

Time _____ : _____

- Call patient to schedule
Patient will call to schedule
Return patient to the office with films
Call STAT (____) _____ - _____
Fax STAT (____) _____ - _____
Fax Routine (____) _____ - _____
Send: CD ROM Films

Additional reports to: _____

Follow-Up Appointment:

Date _____ - _____ - _____

Time _____ : _____

PCP: _____

Name of insurance is required: _____

Insurance authorization # (if needed): _____

CT Exam

Contrast at radiologist's discretion unless No

- Head, Sinus, Orbit/Temp. bones, C-Spine, T-Spine, L-Spine, KUB
Chest, Abdomen (specify), Abdomen & Pelvis (specify), Pelvis (specify), Enterography, Other
CTA Head & Neck, CTA Chest, CTA Abdomen, CTA Abdomen & Pelvis, CTA Pelvis, CTA Attn:, Other

High Field Open MRI Exam

Contrast at radiologist's discretion unless No Pacemaker: Y / N

- Head, Soft Tissue, C-Spine, T-Spine, L-Spine, MRCP, Abdomen, Pelvis, MRA, Other

Extremity

- Hand, Wrist, Elbow, Shoulder, Hip, Knee, Ankle, Foot, Other

Referring Provider Signature (Required for Exam)

Radiology Order Form

PLEASE GIVE AT LEAST 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT

This Referral is confidential and is intended solely for the use of the medical provider named above. If you are not the intended recipient or the intended recipient's agent, and have received this communication in error, notify sender immediately and destroy this document.