EvergreenHealth

EvergreenHealth Scheduling: 425.899.2831
EvergreenHealth Fax: 425.899.2828
www.evergreenhealth.com/imaging

DIAGNOSTIC IMAGING

Exam Order Form

(See reverse side for addresses and maps.)

EVERGREEN RADIA IMAGING CENTER

Scheduling: 425.899.2831
EvergreenHealth Radia Fax: 425.952.6150
EvergreenHealth Radia Phone: 425.952.6100
www.radiax.com

PATIENT INFORMATION

Patient Name ______ LAST ______ FIRST ______ MI

Primary Phone ______ DOB ______ Height ______ Weight ______

Diagnosis & Symptoms-*Required* ______

❑ Call Patient to Schedule ❑ Patient will Call ❑ Confirm order has been received by: ❑ Fax ❑ Phone

ICD-10 #-Required ______

Insurance ______

ID/Claim # ______

Authorization # ______

Is exam due to an injury? ❑ Yes ❑ No

Date of Injury ______

INFORMATION REQUIRED BY CMS

HCPCS Code ______

HCPCS Modifier ______

Decision Support Number ______

Score ______

MRI SCAN *Circle Desired Contrast*

❑ Brain	WO	W/WO	PRN
❑ Abdomen	WO	W/WO	PRN
❑ Cervical Spine	WO	W/WO	PRN
❑ Thoracic Spine	WO	W/WO	PRN
❑ Lumbar Spine	WO	W/WO	PRN
❑ Pelvis	WO	W/WO	PRN
❑ Breast		W/WO	PRN
❑ Breast Silicone Implant Eval. - *WO/Contrast*			
❑ Extremity	WO	W/WO	PRN

Indicate Body Part ______
R L BIL

❑ Arthrogram to Include Contrast Injection

Indicate Joint ______
R L BIL

❑ ______ WO W/WO PRN

REPORT/FILM/CD REQUEST

❑ **ROUTINE** ❑ Call Report # ______

❑ **STAT** ❑ Fax Report # ______

❑ Call Report/Patient Waiting

❑ Patient to Return with CD

❑ CC Report to Another Doctor:

______

______

______

______

ULTRASOUND

❑ Abdomen Complete

❑ Abdomen- RUQ only

❑ Pelvis - *Transvaginal & Transabdominal* ❑ *w/Doppler*

❑ Pelvis - *Transvaginal Only* ❑ *w/Doppler*

❑ Pelvis - *Transabdominal Only* ❑ *w/Doppler*

❑ Renal

❑ Thyroid

❑ LOWER Venous Doppler	R	L	BIL
❑ UPPER Venous Doppler	R	L	BIL
❑ LOWER Arterial Doppler	R	L	BIL
❑ UPPER Arterial Doppler	R	L	BIL

❑ Carotid Doppler

❑ OB - *First Trimester, Up to 11 Weeks: Transvaginal & Transabdominal*

❑ Scrotum ❑ *w/Doppler*

❑ ______

CT SCAN *Circle Desired Contrast*

❑ Chest	WO	W	PRN
❑ Abdomen	WO	W	PRN

NOTE: CT Abdomen Only Covers to Iliac Crest

❑ Pelvis	WO	W	PRN
❑ Chest/Abdomen/Pelvis	WO	W	PRN
❑ Chest/Abdomen	WO	W	PRN
❑ Abdomen/Pelvis	WO	W	PRN
❑ Head	WO	W/WO	PRN
❑ Soft Tissue Neck	WO	W	PRN

❑ Chest Angio PE - *IV Contrast Mandatory*

❑ Chest Angio Aorta - *IV Contrast Mandatory*

❑ Abdomen/Pelvis Angio - *IV Contrast Mandatory*

❑ Myelogram to Include Injection
❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Extremity WO W PRN

Indicate Body Part ______
R L BIL

Circle if: MAKO or CONFORMIS

❑ ______ WO W PRN

❑ ______

NUCLEAR MEDICINE

❑ Bone Scan - Whole Body

❑ Bone Scan - 3 Phase

❑ HIDA with Ejection Fraction

❑ Lasix Renogram

❑ Gastric Emptying

❑ Thyroid Uptake Scan

❑ SPECT CT

Body Part ______

❑ ______

XRAY

❑ Chest ❑ PA ❑ PA and LAT

❑ Abdomen - *Supine*

❑ Abdomen - *Supine and Upright*

❑ Abdomen Series - *Supine, Upright and PA Chest*

❑ Spine ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Scoliosis Survey Standing ❑ AP ❑ AP and LAT

❑ Metastatic Bone Survey

❑ Pelvis

❑ Hip - *includes AP Pelvis*	R	L	BIL
❑ Ribs - *W/ PA Chest*	R	L	BIL

❑ Extremity ______
R L BIL

❑ Fluoro/Injection ______

❑ Other *(Please specify)* ______

❑ ______

NOTES

______

______

______

______

______

______

______

______

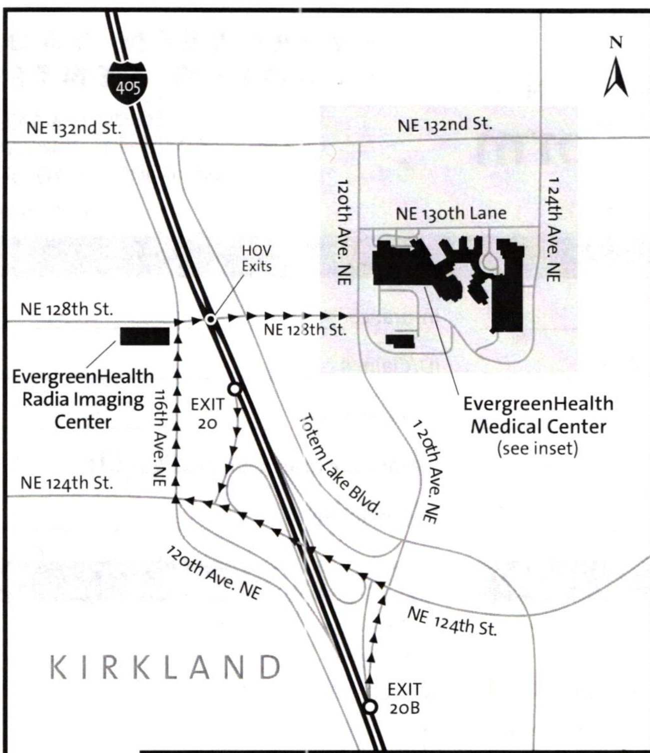
______

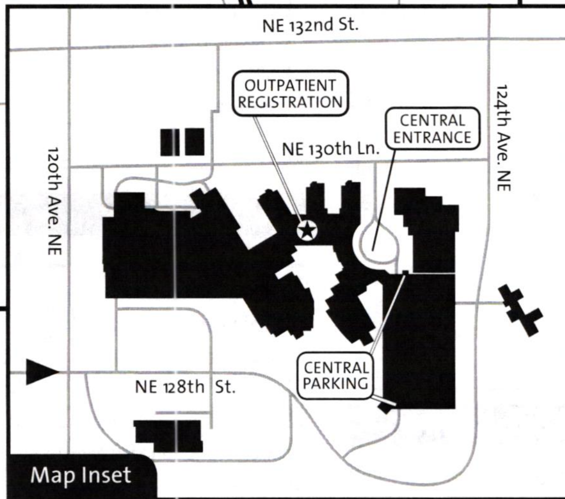
______

REFERRING DOCTOR

Name ______ Phone ______ Fax ______

Signature-*Required* ______ Date-*Required* ______

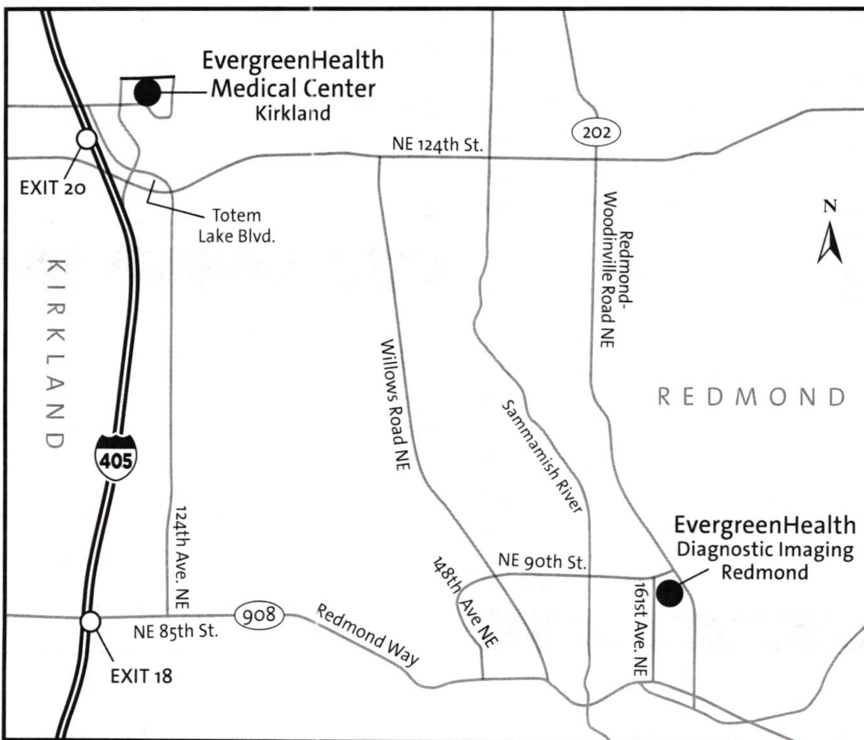




KIRKLAND

EvergreenHealth Medical Center
Diagnostic Imaging - Kirkland
425.899.2831
12040 NE 128th St.
Kirkland, WA 98034

Evergreen Radia
Imaging Center
425.952.6100
866.748.7226 (toll-free)
11521 NE 128th St., Suite 200
Kirkland, WA 98034



REDMOND

EvergreenHealth
Diagnostic Imaging - Redmond
425.895.4810
8980 161st Ave. NE, Suite 340
Redmond, WA 98052