

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
- Calcaneous (heel) L R Bi-lat
- Foot L R Bi-lat
- Toe L R Bi-lat
- Specify digit: _____
- Other: _____

FLUOROSCOPY

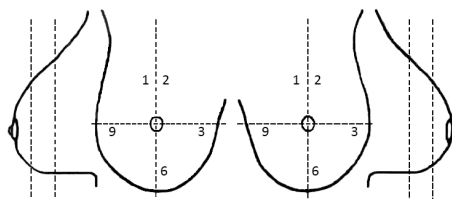
- HSG
- Esophagram
- Upper GI Series
- Cystogram
- Other: _____

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
 - Galactogram: R/L
 - 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 #: _____

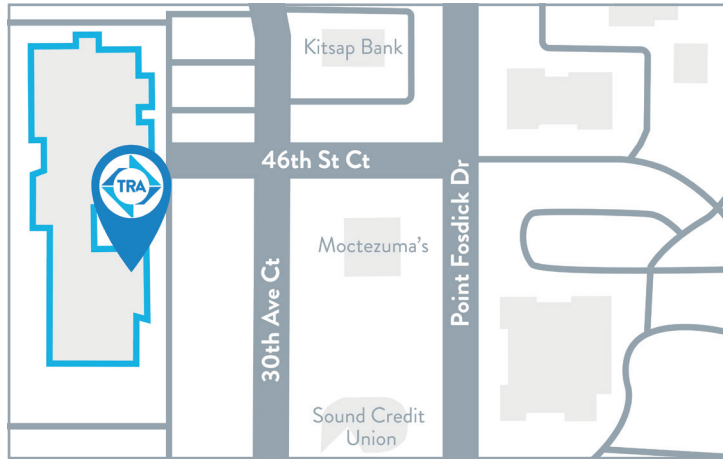
ULTRASOUND

- 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)
- Hysterosonogram
- 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: _____

LOCATIONS

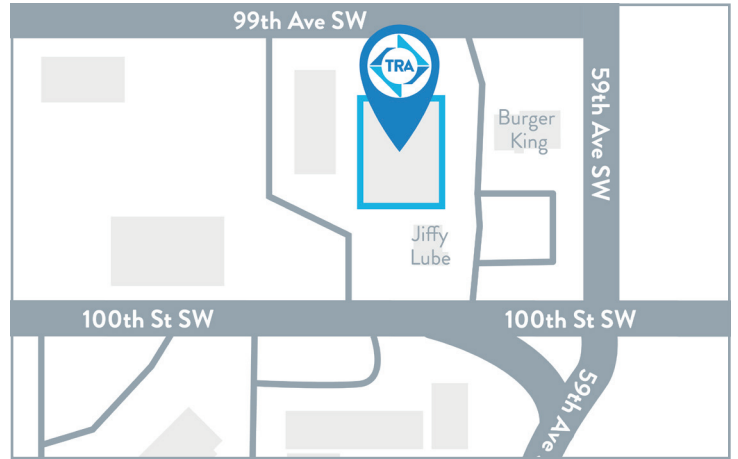
❑ TRA GIG HARBOR

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



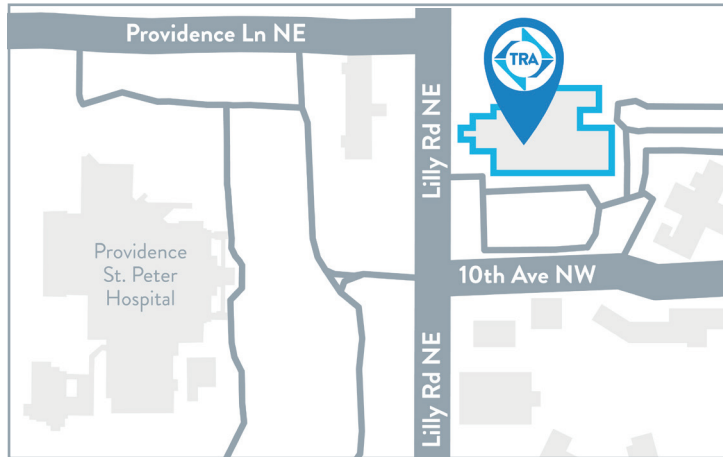
❑ TRA LAKEWOOD

5919 100th St SW, Lakewood WA 98499



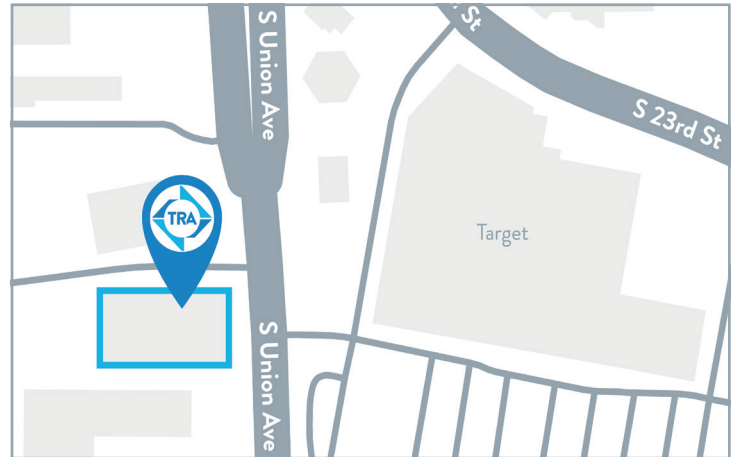
❑ TRA OLYMPIA - ON LILLY

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.