FAX ORDER FORM
Radiology Referral Forms and Location Maps

Date _____

PROVIDER SPECIALTY: Primary Care / Multi-Specialty / Specialty / Alternative *(Circle One)*

Provider Name _____ _____ _____ Title _____
Last First MI

U.P.S. / SHIP TO ADDRESS

Attention _____

Facility Name _____

Number Street Suite _____

City _____ WA _____ Zip

P.O. BOX / MAILING ADDRESS

Attention _____

Facility Name _____

Post Office Box _____

City _____ WA _____ Zip

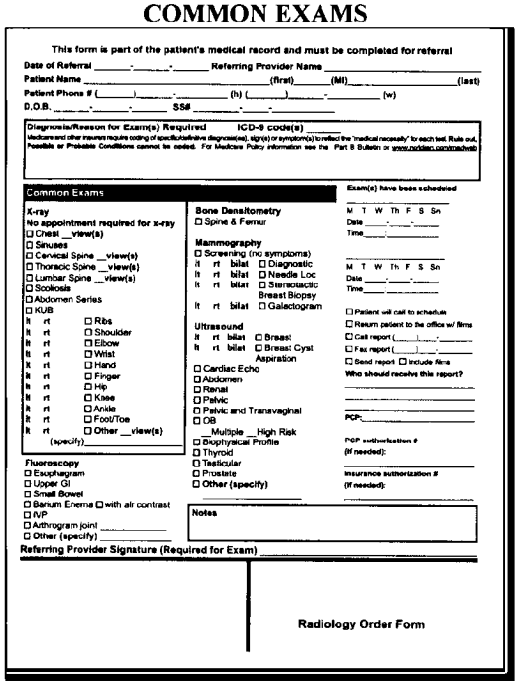
Facility Contact:

Name _____

Phone ( ) _____ - _____ ext. _____

FAX ( ) _____ - _____

COMMON EXAMS


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 # (_____) _____ (h) (_____) _____ (w)
D.O.B. _____ SS# _____

Diagnosis/Reason for Exam(s) Required ICD-9 code(s) _____

Common Exams

X-ray
No appointment required for x-ray
☐ Chest __view(s)
☐ Sinuses
☐ Cervical Spine __view(s)
☐ Thoracic Spine __view(s)
☐ Lumbar Spine __view(s)
☐ Scoliosis
☐ Abdomen Series
☐ KUB
lt rt ☐ Ribs
lt rt ☐ Shoulder
lt rt ☐ Elbow
lt rt ☐ Wrist
lt rt ☐ Hand
lt rt ☐ Finger
lt rt ☐ Hip
lt rt ☐ Knee
lt rt ☐ Ankle
lt rt ☐ Foot/Toe
lt rt ☐ Other __view(s)
(specify) _____

Fluoroscopy
☐ Esophagram
☐ Upper GI
☐ Small Bowel
☐ Barium Enema ☐ with air contrast
☐ IVP
☐ Arthrogram joint _____
☐ Other (specify) _____

Bone Densitometry
☐ Spine & Femur

Mammography
☐ Screening (no symptoms)
lt rt bilat ☐ Diagnostic
lt rt bilat ☐ Needle Loc
lt rt bilat ☐ Stereotactic Breast Biopsy
lt rt bilat ☐ Galactogram

Ultrasound
lt rt bilat ☐ Breast
lt rt bilat ☐ Breast Cyst Aspiration
☐ Cardiac Echo
☐ Abdomen
☐ Renal
☐ Pelvic
☐ Pelvic and Transvaginal
☐ OB
__Multiple __High Risk
☐ Biophysical Profile
☐ Thyroid
☐ Testicular
☐ Prostate
☐ Other (specify) _____

Exam(s) have been scheduled
M T W Th F S Sn
Date _____
Time _____

☐ Patient will call to schedule
☐ Return patient to the office w/ films
☐ Call report (_____) _____
☐ Fax report (_____) _____
☐ Send report ☐ Include films
Who should receive this report?
_____
PCP: _____
PCP authorization # (if needed): _____
Insurance authorization # (if needed): _____

Notes

Referring Provider Signature (Required for Exam) _____

Radiology Order Form

☐ 2 Pads ☐ 10 Pads
☐ 6 Pads ☐ 20 Pads

MHS005

FACILITY MAPS

Including:

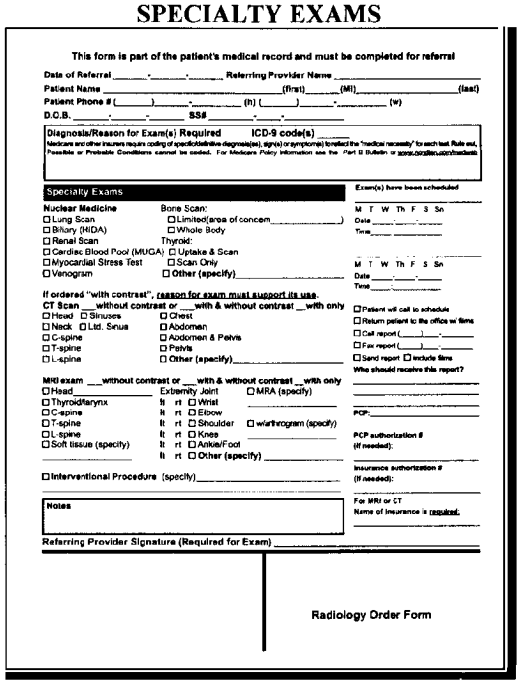
Federal Way
Gig Harbor
Lakewood
Puyallup
Tacoma

(50 Maps per Pack)

☐ 2 Packs ☐ 10 Packs
☐ 6 Packs ☐ 20 Packs

MHS012

SPECIALTY EXAMS


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 # (_____) _____ (h) (_____) _____ (w)
D.O.B. _____ SS# _____

Diagnosis/Reason for Exam(s) Required ICD-9 code(s) _____

Specialty Exams

Nuclear Medicine
☐ Lung Scan
☐ Biliary (HIDA)
☐ Renal Scan
☐ Cardiac Blood Pool (MUGA)
☐ Myocardial Stress Test
☐ Venogram

Bone Scan:
☐ Limited(area of concern _____)
☐ Whole Body

Thyroid:
☐ Uptake & Scan
☐ Scan Only
☐ Other (specify) _____

If ordered "with contrast", reason for exam must support its use.
CT Scan __without contrast or __with & without contrast __with only
☐ Head ☐ Sinuses
☐ Neck ☐ Ltd. Sinus
☐ C-spine
☐ T-spine
☐ L-spine
☐ Chest
☐ Abdomen
☐ Abdomen & Pelvis
☐ Pelvis
☐ Other (specify) _____

MRI exam __without contrast or __with & without contrast __with only
☐ Head _____
☐ Thyroid/larynx
☐ C-spine
☐ T-spine
☐ L-spine
☐ Soft tissue (specify) _____

Extremity Joint
lt rt ☐ Wrist
lt rt ☐ Elbow
lt rt ☐ Shoulder
lt rt ☐ Knee
lt rt ☐ Ankle/Foot
lt rt ☐ Other (specify) _____

☐ MRA (specify) _____
☐ w/arthrogram (specify) _____

☐ Interventional Procedure (specify) _____

Exam(s) have been scheduled
M T W Th F S Sn
Date _____
Time _____

☐ Patient will call to schedule
☐ Return patient to the office w/ films
☐ Call report (_____) _____
☐ Fax report (_____) _____
☐ Send report ☐ Include films
Who should receive this report?
_____
PCP: _____
PCP authorization # (if needed): _____
Insurance authorization # (if needed): _____
For MRI or CT
Name of insurance is required: _____

Notes

Referring Provider Signature (Required for Exam) _____

Radiology Order Form

☐ 2 Pads ☐ 10 Pads
☐ 6 Pads ☐ 20 Pads

MHS007

Please ***TOLL-FREE FAX*** this Order Form to:

Advent Print Resources

1-800-959-6250

Orders received in our warehouse by noon will be shipped that day, or mailed the following morning.

12620 B Interurban Avenue South
Tukwila, WA 98168 • 800-927-7012

COMMENTS: _____

#MHS009 1/10/02