



SouthSound RADIOLOGY

www.southsoundradiology.com

3417 Ensign Road NE • Olympia, WA 98506-5075
(360) 252-9301 or 1-866-374-2635 / FAX (360) 455-5442

DIAGNOSTIC IMAGING OUTPATIENT ORDER FORM

- Call PT to schedule appt. PT to call & schedule appt.
- Walk In Interpreter: _____ Physical Assistance
- FAX BACK w/: DATE: _____ TIME: _____
- PT to return w/ CD unless otherwise specified

DATE: ____ / ____ / ____

PATIENT NAME (Last, First, M.I.): _____ GENDER: M ___ F ___

PT's D.O.B.: _____ PHONE #1: _____ PHONE #2: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

INSURANCE: _____ AUTHORIZATION NO: _____ CC: _____

Creatinine blood draw at radiologist's discretion NO SERUM CREATININE RESULTS: _____ DATE: _____ LAB: _____

HISTORY/Relevant Clinical Diagnosis: _____

SYMPTOM(S) / SIGN(S): _____

REASON/ICD-10 CODE: _____

INJURY OCCURRENCE: _____

PROVIDER: _____

Signature

Printed Name

MRI / MRA

CONTRAST AT DISCRETION OF RADIOLOGIST NO

- | | | | |
|--|--|----|----|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | Lt | Rt |
| <input type="checkbox"/> Brain MRA | <input type="checkbox"/> MR arthrogram | Lt | Rt |
| <input type="checkbox"/> MRA Neck (Carotids) | | Lt | Rt |
| <input type="checkbox"/> MRA _____ | <input type="checkbox"/> Forearm | | |
| <input type="checkbox"/> Soft tissue neck | <input type="checkbox"/> Elbow | Lt | Rt |
| <input type="checkbox"/> C-spine | <input type="checkbox"/> Wrist <input type="checkbox"/> Hand | Lt | Rt |
| <input type="checkbox"/> T-spine | <input type="checkbox"/> Femur | Lt | Rt |
| <input type="checkbox"/> L-spine | <input type="checkbox"/> Knee | Lt | Rt |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Foot <input type="checkbox"/> Ankle | Lt | Rt |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Pelvis OR <input type="checkbox"/> Hip | Lt | Rt |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> TMJ | Lt | Rt |
| <input type="checkbox"/> MRCP | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Orbits | | | |

X-RAY

- | | |
|--|---|
| <input type="checkbox"/> Orbits for foreign body | <input type="checkbox"/> Abd 1V <input type="checkbox"/> 2V |
| <input type="checkbox"/> Sinus waters view <input type="checkbox"/> complete | <input type="checkbox"/> C-spine 2V |
| <input type="checkbox"/> Chest 2V <input type="checkbox"/> 1V (PA) | <input type="checkbox"/> C-spine w/oblique |
| <input type="checkbox"/> Ribs | Lt Rt <input type="checkbox"/> C-spine obl, flex & extension |
| <input type="checkbox"/> Shoulder | Lt Rt <input type="checkbox"/> T-spine |
| <input type="checkbox"/> Humerus | Lt Rt <input type="checkbox"/> L-spine 2V |
| <input type="checkbox"/> Elbow | Lt Rt <input type="checkbox"/> L-spine w/oblique |
| <input type="checkbox"/> Forearm | Lt Rt <input type="checkbox"/> L-spine w/flex & extension |
| <input type="checkbox"/> Wrist <input type="checkbox"/> Hand | Lt Rt <input type="checkbox"/> Epidural inj Level: _____ |
| <input type="checkbox"/> Finger | Lt Rt <input type="checkbox"/> Facet injection |
| <input type="checkbox"/> Hip | Lt Rt Levels: _____ Lt Rt |
| <input type="checkbox"/> Pelvis AP | Lt Rt <input type="checkbox"/> Nerve root injection |
| <input type="checkbox"/> Femur | Lt Rt Levels: _____ Lt Rt |
| <input type="checkbox"/> Knee | Lt Rt <input type="checkbox"/> IVP |
| <input type="checkbox"/> Tib/Fib | Lt Rt <input type="checkbox"/> UGI <input type="checkbox"/> SBFT |
| <input type="checkbox"/> Foot <input type="checkbox"/> Ankle | Lt Rt <input type="checkbox"/> Barium enema <input type="checkbox"/> BE w/air |
| <input type="checkbox"/> Heel <input type="checkbox"/> Toes | Lt Rt <input type="checkbox"/> Barium swallow (esophagram) |
| <input type="checkbox"/> Hysterosalpingogram | <input type="checkbox"/> Joint Injection _____ |

CT

CONTRAST AT DISCRETION OF RADIOLOGIST NO

- | | |
|--|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> KUB w/ 1 view ABD x-ray |
| <input type="checkbox"/> Orbits <input type="checkbox"/> Temp bones | <input type="checkbox"/> C-spine _____ |
| <input type="checkbox"/> Sinus <input type="checkbox"/> 4-view screening | <input type="checkbox"/> T-spine levels _____ |
| OR <input type="checkbox"/> coronal full | <input type="checkbox"/> Upper extr. _____ |
| <input type="checkbox"/> Soft-tissue neck | <input type="checkbox"/> Lower extr. _____ |
| <input type="checkbox"/> Chest | <input type="checkbox"/> CT herniagram |
| <input type="checkbox"/> Abdomen & pelvis | <input type="checkbox"/> Nerve root injection |
| <input type="checkbox"/> Abdomen | Levels: _____ Lt Rt |
| <input type="checkbox"/> Pelvis | |

DEXA

- Body Fat Composition
- Bone Density
- Instant Vertebral Assessment

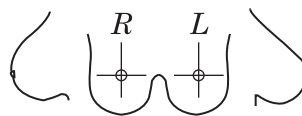
ULTRASOUND

- | | |
|--|---|
| <input type="checkbox"/> OB complete | <input type="checkbox"/> Pelvis and TV |
| <input type="checkbox"/> OB limited | <input type="checkbox"/> Hysterosonography |
| <input type="checkbox"/> OB bio profile | <input type="checkbox"/> Carotids |
| <input type="checkbox"/> Abdomen complete | <input type="checkbox"/> Aorta (for AAA) |
| <input type="checkbox"/> RUQ/Gallbladder/Liver | <input type="checkbox"/> Aorta (Medicare Screening) |
| <input type="checkbox"/> Liver Elastography | <input type="checkbox"/> Renal |
| <input type="checkbox"/> Bladder Pre / Post void | <input type="checkbox"/> Vascular DVT |
| <input type="checkbox"/> Testicles | <input type="checkbox"/> Thyroid / neck soft tissue |
| <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Thyroid Bx |
| <input type="checkbox"/> Musculoskeletal _____ | <input type="checkbox"/> Extremity |
| | <input type="checkbox"/> Other _____ |

BREAST IMAGING

- Screening Mammography
- Diagnostic Mammography
- Breast Ultrasound
- Biopsy w/ post biopsy mammogram
- Ductogram
- Ultrasound Breast Cyst Asp (Breast Ultrasound If Indicated)
- Needle Loc
- Consult/Add views if needed

Other breast imaging at radiologist's discretion NO including breast ultrasound



Document Palp Abn
O'clock _____
N+ _____

If you are unable to keep your appointment, please give 24-hour notice.

If you are scheduled for an IVP, CT or MRI exam, biopsy or aspiration -- please telephone South Sound Radiology at (360) 252-9301 OR 1-866-374-2635 as soon as you are aware of your appointment. Certain conditions warrant special instruction.

EXAMINATION PREPARATION

- CT Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. If you are taking glucophage, metformin or glucovance--immediately alert SSR schedulers of this fact.
- MRI Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. Wear metal-free clothing and leave valuables at home.
- DEXA Day of exam: No calcium or vitamin supplements. Wear metal-free clothing.
- JOINT/SPINE INJECTION & BIOPSIES ATTENTION: IF YOU ARE A PATIENT ON BLOOD THINNERS AND HAVING ONE OF THESE PROCEDURES, YOU WILL NEED TO CALL FOR PREPARATION INSTRUCTIONS.
- Mammography Use no perfume, body powder, or deodorant on the day of the exam. You will be asked to undress from the waist up for this exam. Please **wear a 2-piece outfit** the day of your scheduled appointment.

ULTRASOUND

- Abdominal Ultrasound Night before exam: Fat-free dinner the night before. Nothing to eat or drink after midnight. Non-fat liquids permitted 6 hours prior to exam. No gum chewing or smoking.* Nothing to eat or drink (including gum) from midnight. No smoking.*
- Aorta Ultrasound Night before exam: Fat-free dinner the night before. Nothing to eat or drink after midnight. Non-fat liquids permitted 6 hours prior to exam. No gum chewing or smoking.*
- Gallbladder/RUQ Ultrasound 1 hour **prior** to exam:
 - 1) Empty your bladder;
 - 2) Drink 32 ounces water within the next 20 minutes;
 - 3) Do not empty your bladder again.
- Pelvis Ultrasound 1 hour **prior** to exam:
 - 1) Empty your bladder;
 - 2) Drink 16-24 ounces water within the next 20 minutes;
 - 3) Do not empty your bladder again.
- Renal/Bladder Ultrasound 1 hour **prior** to exam:
 - 1) Empty your bladder;
 - 2) Drink 16-24 ounces water within the next 20 minutes;
 - 3) Do not empty your bladder again.

PLEASE DO NOT BRING CHILDREN TO YOUR APPOINTMENT.

OB Ultrasound

- 1st Trimester 1 hour **prior** to exam:
 - 1) Empty your bladder;
 - 2) Drink 32 ounces water within the next 20 minutes;
 - 3) Do not empty your bladder again.
- 2nd Trimester 1 hour **prior** to exam:
 - 1) Empty your bladder;
 - 2) Drink 18-24 ounces water within the next 20 minutes;
 - 3) Do not empty your bladder again.
- 3rd Trimester No preparation required.
- Biophysical Ultrasound No preparation required.

PLEASE DO NOT BRING CHILDREN TO YOUR APPOINTMENT.

X-RAY

- Colon X-Ray (Barium Enema) Wear metal-free clothing to your appointment. Two days **prior** to exam -- Clear liquids after 12 noon. One day **prior** to exam -- Purchase Colyte (a prescription from your doctor) and begin drinking at 3 PM according to manufacturer's directions. Drink the entire solution. If you feel full or nauseated, wait 30 minutes and start again. Nothing to eat or drink after midnight.
- Kidney X-Ray (IVP) Day of exam: Nothing to eat or drink after midnight. Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. If you are taking glucophage, metformin or glucovance--immediately alert SSR schedulers of this fact.
- UGI/SBFT Day of exam: Nothing to eat (including gum), drink or smoke after midnight or for 6 hours before your exam.*

* **PRESCRIPTION MEDICATIONS CAN BE TAKEN WITH A SMALL AMOUNT OF WATER**

FOR OFFICE USE ONLY

South Sound Radiology FAX # 360-455-5442