

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 _____ Breast cancer history Lt _____ Rt _____
 Mastectomy history Lt _____ Rt _____
 Allergies _____ Implants? Y _____ N _____
 Physical Assistance Required

PRIOR EXAMS:

 Date of Service _____ Facility Location _____

Breast Imaging & Bone Density

Screening Services

Mammography

Screening Mammogram (no symptoms)

Bone Densitometry (DEXA)

Spine & Femur

Other (Specify) _____

Diagnostic Services

Diagnostic Mammogram **lt rt bilat**
 (Ultrasound if needed)

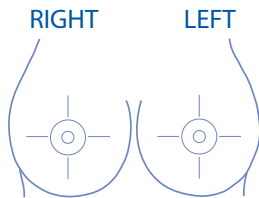
Needle Biopsy if indicated

Needle Loc **lt rt bilat**

Stereotactic Breast Biopsy **lt rt bilat**

Galactogram **lt rt bilat**

Indicate area of concern



Ultrasound

Breast **lt rt bilat**

Breast Cyst Aspiration **lt rt bilat**

Guided Breast Biopsy **lt rt bilat**

MRI exam

Pacemaker: Y / N (if YES, MRI services unavailable)

BUN/Creatinine ____ / ____ (date drawn) ____ / ____ / ____

Breast MRI bilat with contrast

Limited Chest MRI if indicated (radiologist's discretion)

Breast MRI guided biopsy **lt rt bilat**

Other Last Name: _____

Appointments:

Exam _____

Day/Date: _____ - _____ - _____

Check In Time _____ : _____

Appt. Time _____ : _____

Exam _____

Day/Date: _____ - _____ - _____

Check In Time _____ : _____

Appt. 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: _____

PCP: _____

Name of insurance is required:

Insurance authorization #
 (if needed): _____

Referring Provider Signature
 (Required for Exam) →

For Office Use Only

Diagnostic Imaging Phys Orders



Radiology Order Form

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.

Preparing for your Mammogram:

- Please wear a two-piece outfit
- Wear no deodorant or powder

*Bone Densitometry
Mammogram - Screening
Mammogram - Diagnostic
Breast Ultrasound
Needle Localization
Breast Biopsy
Galactogram
Breast MRI
Breast Cyst Aspiration*

Tacoma

- ❑ **Carol Milgard Breast Center**
4525 South 19th Street Tacoma, WA 98405
scheduling (253) 759-2622 (866) 758-2622
scheduling fax (253) 572-4324
- ❑ **St. Joseph Medical Center Dept of Radiology** (Franciscan)
1717 South J Street, Tacoma WA 98405
(253) 426-6620 fax (253) 426-6610

Gig Harbor

- ❑ **Milgard Medical Pavilion at St. Anthony Hospital** (Franciscan)
11511 Canterwood Blvd NW, Gig Harbor WA 98332
Scheduling (253) 530-2170 fax (253) 530-2178
- ❑ **MultiCare Women's Health & Wellness Center at Gig Harbor Medical Park**
4545 Pt. Fosdick Dr. NW, Suite 130, Gig Harbor WA 98335
(253) 530-8122, scheduling (253) 403-1059, fax (253) 530-8126

Bonney Lake

- ❑ **Diagnostic Imaging Northwest Bonney Lake Imaging Center**
21110 SR 410 East, Suite 110, Bonney Lake, WA 98391
(253) 841-4353 fax (253) 446-3973

Federal Way

- ❑ **The Women's Health Center at St. Francis Medical Pavilion** (Franciscan)
34503 9th Avenue South, Suite 320, Federal Way WA 98003
(253) 944-4021 fax (253) 944-4023
- ❑ **St. Francis Hospital Dept of Radiology** (Franciscan)
34515 9th Avenue South, Federal Way WA 98003
(253) 944-4133 fax (253) 944-7557

Lakewood

- ❑ **St. Clare Specialty Center** (Franciscan)
11307 Bridgeport Way Southwest, Lakewood WA 98499
(253) 985-6395 fax (253) 985-2831
- ❑ **TRA Medical Imaging-Lakewood**
5919 100th Street Southwest, Lakewood WA 98499
scheduling (253) 761-4200 (866) 761-4200
scheduling fax (253) 761-4201 clinic fax (253) 588-3870

Puyallup

- ❑ **Diagnostic Imaging Northwest Puyallup Imaging Center**
222 15th Avenue Southeast, Puyallup WA 98372
(253) 841-4353 fax (253) 446-3973
- ❑ **Diagnostic Imaging Northwest Sunrise Imaging Center**
11212 Sunrise Blvd. East, Suite 200, Puyallup WA 98374
(253) 841-4353 fax (253) 446-3973
- ❑ **Meridian Bone Density Specialists**
11019 Canyon Road East, Puyallup WA 98373
(253) 536-2972 fax (253) 826-4558

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