RADIOLOGY REFERRAL FORM - COMMON

TRA MEDICAL IMAGING

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: _____

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 #: _____

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

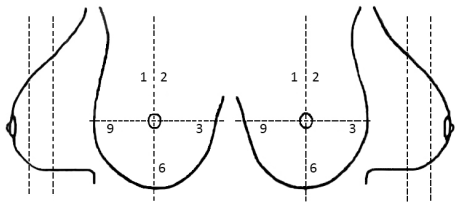
❑ Esophagram
❑ Upper GI Series
❑ Cystogram
❑ Other: _____

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
❑ 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+: _____

ULTRASOUND

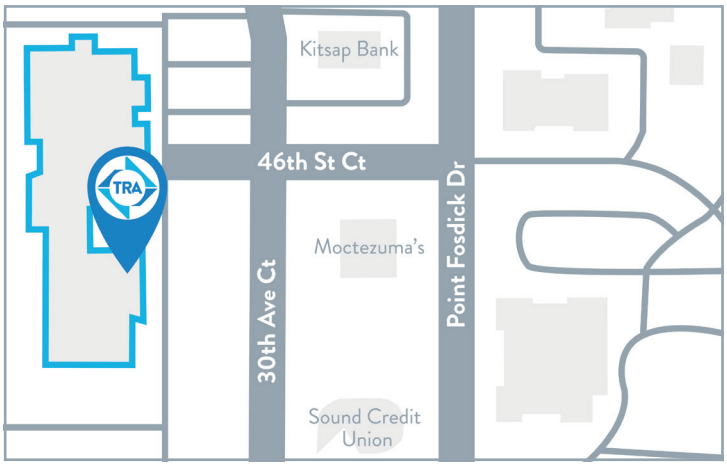
❑ Thyroid/Neck
❑ Abdomen- Complete
❍ Elastography
❑ Abdomen- Limited: _____
❑ Renal
❑ AAA Screen *(Medicare only- once a lifetime)*
❑ AAA follow-up *(retroperitoneal, limited)*
❑ Appendix
❑ Pelvic *(transabdominal and/or transvaginal as needed for diagnostic visualization)*
❑ Bladder Post-Void Residual
❑ 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 ❍ Pyloris
❑ 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: _____

Referring Provider Signature (Required for exam) → _____

LOCATIONS

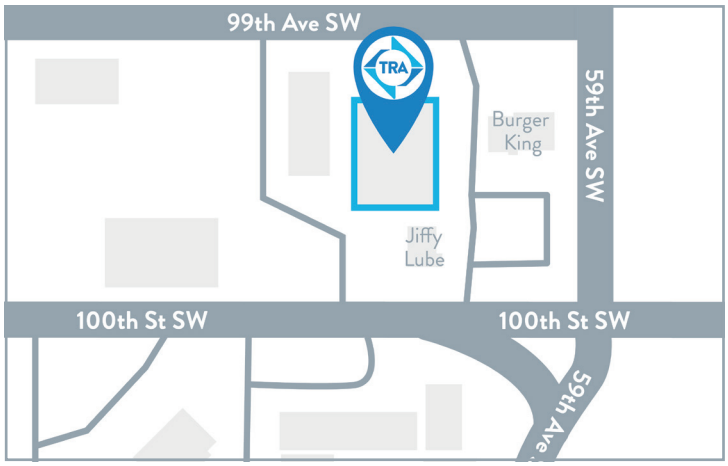
❑ TRA GIG HARBOR

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



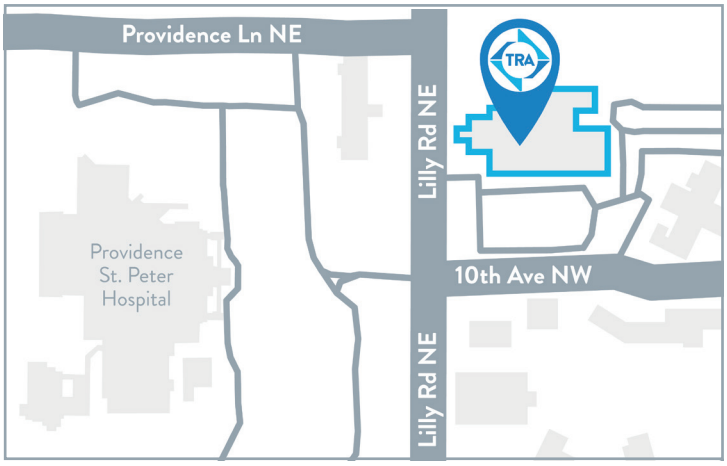
❑ TRA LAKEWOOD

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.

Pierce County Phone: 253-761-4200
Pierce County Fax: 253-761-4201
Thurston County Phone: 360-413-8383
Thurston County Fax: 360-413-8323