BELLINGHAM ADVANCED MEDICAL IMAGING

DIAGNOSTIC IMAGING ORDER FORM

SCHEDULING (360) 255–6330
FAX REFERRAL (360) 255–6331

Patient Name: _____ **Date of Referral:** _____ / _____ / _____

Date of Birth: _____ / _____ / _____ **Gender:** ☐ Female ☐ Male

Phone: (_____) _____ – _____ ☐ **Diabetic** ☐ **Pregnant** **Weight:** _____

Primary Insurance: _____ **ID Number:** _____

☐ **Motor Vehicle** ☐ **Workers Compensation** **Authorization #:** _____

Patient Needs:
☐ Claustrophobia
☐ Sedation ☐ Disability
☐ Allergies: _____
☐ Language: _____
☐ Other: _____

CLINICAL INDICATORS Reason for exam to support medical necessity. No abbreviations. No "rule outs."

ICD-10 Code(s):

☐ **Routine** ☐ **STAT**
☐ **Expedited**
☐ **Send With Patient (CD)**
☐ **Call Report:** _____
☐ **Fax Report:** _____

REFERRING PROVIDER

Clinic/Location: _____ **Phone:** (_____) _____–_____ **Fax:** (_____) _____–_____

Provider Name: _____ **Provider Signature:** _____

ORIGINAL SIGNATURE REQUIRED. DO NOT USE STAMP.

MRI

☐ **WITH CONTRAST** ☐ **WITHOUT CONTRAST** ☐ **RADIOLOGIST DISCRETION**

☐ **Abdomen** ☐ MRA
Protocol: ☐ Adrenal ☐ Enterography ☐ Hepatic ☐ MRCP ☐ Pancreas ☐ Renal

☐ **Brain** ☐ MRA
Protocol: ☐ AC ☐ MS ☐ Pituitary ☐ Seizure ☐ Stroke

☐ **Extremity – Lower** ☐ LT ☐ RT ☐ Bilateral
☐ Ankle ☐ Femur ☐ Foot ☐ Hip ☐ Knee ☐ Pelvis ☐ Tibia / Fibula
☐ Arthrogram (Specify Joint): _____

☐ **Extremity – Upper** ☐ LT ☐ RT ☐ Bilateral
☐ Elbow ☐ Forearm ☐ Humerus ☐ Shoulder ☐ Wrist
☐ Arthrogram (Specify Joint): _____
☐ Finger (Specify Digit): _____

☐ **Neck** ☐ MRA

☐ **Orbits**

☐ **Pelvis** ☐ MRA ☐ Gynecological ☐ Prostate ☐ Sacroiliac Joint

☐ **Spine** ☐ Cervical ☐ Lumbar ☐ Thoracic

☐ **Other:** _____

ULTRASOUND

☐ **Abdomen** ☐ With Limited Duplex of the Liver Vessels

☐ **Breast Abscess** ☐ LT ☐ RT ☐ Bilateral

☐ **Extremity – Non-Vascular** ☐ LT ☐ RT
Specify Joint: _____

☐ **Obstetric**
☐ 1st Trimester ☐ 1st Trimester – Twins
☐ 2nd / 3rd Trimester ☐ 2nd / 3rd Trimester – Twins
☐ 2nd / 3rd Trimester – Limited (Specify): _____
☐ Other: _____

☐ **Pelvis** (Endovaginal & Transabdominal) ☐ Transabdominal Only

☐ **Retroperitoneum** ☐ Kidney and Bladder Only

☐ **Sonohysterogram**

☐ **Testicular With Limited Duplex**

☐ **Thyroid**

☐ **Other:** _____

CT

☐ **WITH CONTRAST** ☐ **WITHOUT CONTRAST** ☐ **RADIOLOGIST DISCRETION**

☐ **Brain**
☐ **Maxillofacial**
☐ **Neck**
☐ **Orbits**
☐ **Pelvis**
☐ **Spine** ☐ Cervical ☐ Lumbar ☐ Thoracic
☐ **Sinus**
☐ **Temporal Bones**

☐ **Abdomen**
Protocol: ☐ Adrenal ☐ Hepatic ☐ Pancreas ☐ Renal

☐ **Abdomen–Pelvis**
Protocol: ☐ IVP ☐ KUB ☐ Enterography

☐ **Chest** ☐ **Chest–Abdomen** ☐ **Chest–Abdomen–Pelvis**

☐ **CT Angiography (CTA)**
Protocol: ☐ Aortic Aneurysm ☐ Brain ☐ Dissection (Chest–Abdominal) ☐ Neck ☐ Peripheral Runoff ☐ Pulmonary Embolism

☐ **Extremity – Upper / Lower** ☐ LT ☐ RT ☐ Bilateral
Specify Location: _____
☐ Arthrogram (Specify Joint): _____

☐ **Other:** _____

VASCULAR ULTRASOUND

☐ **Abdominal Aortic Aneurysm Screening**

☐ **Arterial Duplex** ☐ LT ☐ RT ☐ Bilateral
☐ Upper Extremity ☐ Lower Extremity

☐ **Carotid Duplex**

☐ **Vascular Screening**

☐ **Venous Duplex** ☐ LT ☐ RT ☐ Bilateral
☐ Upper Extremity ☐ Lower Extremity

☐ **Other:** _____

FLUOROSCOPY

☐ **Lumbar Puncture**

☐ **Hysterosalpingogram**

X-RAY

☐ LT ☐ RT ☐ Bilateral **# of Views:** _____

Area(s) of Body: _____

_____