GENERAL IMAGING FORM

Fax form to 253.804.2800

Auburn Regional Medical Center

Questions? Call 253.333.2720

PATIENT INFORMATION *(Please Print)*

Patient Name: ______________________________ Date of Birth: ____/____/____
(Last) *(First)* *(MI)*

Home phone: ______________________ Work phone: ______________________

Patient Insurance: ______________________ Insurance Authorization Number: ______________________

PROVIDER INFORMATION

Provider Name: ______________________ cc to Dr.: ______________________

Contact person for questions regarding patient: ______________________

O Call report to: (____)______________________ O Fax results to: ______________________

O Send films: O Patient return w/films

SCHEDULING INFORMATION

Appointment Date: ____________ Appointment Time: ____________ O Patient will call to schedule appointment

Person scheduling exam: ______________________ ICD9 Code: ______________________

Clinical History/Reason for Exam:

____

Special Instructions: ______________________

CT:

- O Abdomen
- O Abd/Pelvis (for kidney stones)
- O Abd/Pelvis (complete)
- O Pelvis
- O Head
- O Extremity____________
- O Other______________________
- O Sinus Limited
- O Sinus Complete
- O Neck
- O Chest
- O Lumbar Spine
- O Cervical Spine

Contrast: With Without If Indicated

Creatinine:____________ Date:__________

Is the patient diabetic? Yes No

If Yes, is patient on glucophage? Yes No

Has patient ever had a contrast reaction? Yes No

Allergies (please specify)________________

Renal Disease? Yes No

Ultrasound:

- O Abdomen/Gallbladder
- O Abdomen/Pelvis
- O Aorta
- O Bladder
- O Thyroid
- O Testes
- O Other______________________
- O Breast: R L
- O Kidneys
- O OB________wks
- O Pelvis (transvag if indicated)
- O Hysterosonogram (saline contrast)

MRI:

Area of exam: ______________________

Contrast: With Without If Indicated

Clinical Diagnosis: ______________________

Symptoms: ______________________

Any previous surgery on area of interest? ______________________

Pacemaker? Yes No

Pregnant? Yes No Have you had a Brain Aneurysm Clipped? Yes No

Any history of metal in eyes or body? Yes No If yes, what area?_________

Any history of surgical implants? Yes No If yes, what? ____________

Nuclear Medicine:

- O Bone Scan
- O Gated Blood Pool (MUGA)
- O Lung V/Q Scan
- O Myocardial Perfusion
- O Gastric Emptying
- O Liver/Spleen Scan
- O Hepatobiliary Scan
- O Schillings
- O Thyroid Uptake and Scan
- O Renal Scan and Function
  - O Diuretic
  - O For Renovascular

Diagnostic:

- O Chest x-ray
- O C-Spine
- O Extremity X-ray:______________________
- O Other:______________________
- O L-Spine
- O T-Spine
- O Abdomen
- O Acute Abdomen Series

Fluoroscopy:

- O Arthogram
- O Cystogram
- O Hysterosalpingogram
- O Small Bowel
- O Barium Enema
- O Esophagram
- O Upper GI

Other:______________________

Creatinine:____________ Date:____________

Is the patient diabetic? Yes No

If Yes, is patient on glucophage? Yes No

Has Patient ever had a contrast reaction? Yes No

Allergies (please specify)______________________

Renal Disease? Yes No

Mammography:

CHOOSE EXAM:

- O Screening
- O Diagnostic Bilateral
- O Diagnostic Unilateral R L

CHOOSE CLINICAL:

- O Follow-up
- O Lump R L
- O Pain R L
- O Ultrasound if indicated

Implants? Yes No Location of Lump: ______________

Previous breast surgery, date: ______________

Previous breast cancer, date: ______________

Provider Signature: ______________________ **Order Date:** ______________

Patient must bring written order to the exam or fax order.