SWEDISH RADIA IMAGING CENTER AT EDMONDS

PODIATRY IMAGING STUDY ORDER FORM

Patient Name: _____ ☐ Male ☐ Female DOB: _____

Phone: _____ /H _____ /C Previous Studies? ☐ No ☐ Yes Facility: _____

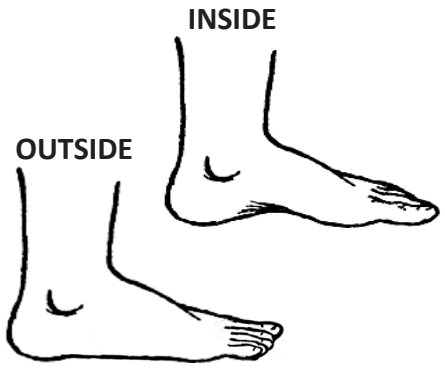
Insurance: _____ Auth Initiated? ☐ No ☐ Yes Auth #: _____

MEDICARE CDS INFO CDSM/G-CODE: _____ Outcome Modifier: _____

1. *CHOOSE EXAM TYPE*

CT:	☐ With Contrast ☐ W/O Contrast ☐ Contrast at Radiologist Discretion ☐ 3D Reformats
MRI:	☐ With Contrast ☐ W/O Contrast ☐ Contrast at Radiologist Discretion
Ultrasound:	☐ LE Venous Study ☐ Other: _____
X-Ray:	☐ Toes ☐ Foot ☐ Ankle ☐ Calcaneus ☐ Tibia/Fibula ☐ Other (Mark Below)

2. *DRAW/SELECT AREAS OF INTEREST*



Area of Interest:

All Exams: ☐ Right ☐ Left ☐ Bilateral

MRI/CT: ☐ Forefoot/Toes ☐ Midfoot ☐ Ankle/Hindfoot

☐ Calf ☐ Other: _____

Clinical Diagnosis & Symptoms:

_____

_____

_____

3. *CHOOSE REPORT TYPE/METHOD OF DELIVERY*

☐ Routine	☐ Stat	☐ Copy Additional Provider	Name:
☐ Fax:	☐ Phone:	☐ Fax:	☐ Phone:
☐ Send images via AMBRA	☐ Email images to:		

4. *ORDERING PROVIDER SIGNATURE:* _____ Date: _____

Please Print Name & Phone _____

5. *FACILITY INFORMATION* ☐ **Call Patient to Schedule** ☐ **Patient Will Call to Schedule**

Swedish Radia Imaging Center at Edmonds
21700 Hwy 99
Edmonds, WA 98026
(425) 640-4949 / Fax: (425) 670-8690

Patient Screening Questions and Information

Does patient have any metal and/or implants in the body/head? (i.e. pacemaker, stents, clips, wires, IUD, replacements, etc.) ☐ Yes ☐ No

If yes, specify: _____

Is patient pregnant? ☐ Yes

Is patient claustrophobic?

☐ Yes ☐ No If yes:

☐ Oral (Provider gives oral Rx to pt.)

☐ IV, Conscious sedation (driver needed)

Creatinine Requirements (MRI Contrast Only)

For patients requiring contrast and having any of the health concerns listed below, creatinine must be drawn within 6 weeks of the MRI exam.

☐ 60+ Years Old ☐ Hypertension
☐ Diabetes ☐ History of Renal Disease
☐ Liver Disease ☐ Current Chemo Patient