SPECIALTY EXAMS

This form is part of the patient's medical records and must be completed for referral

Date of Referral ____________ Referring Provider Name ____________

Patient Name (First, MI, Last) ____________ D.O.B. ____________

Patient Home Phone # (______) ____________ Cell (______) ____________

SS# ____________ Translator Needed (language) ____________

Written Diagnosis / Reason / Symptom for Exam(s) **REQUIRED**

❑ **Radiologist can change order per protocol, unless box is checked**

CPT CODE: ____________ **ICD-10 CODE:** ____________

Height: ______ Weight: ______ Allergies: ____________

Creatinine / GFR: ______ / ______ Date Drawn: ____________

LABS REQUIRED FOR IV CONTRAST STUDIES

❑ **I authorize on-site creatinine if needed.** ❑ **I authorize on site albumin as needed.**

NUCLEAR MEDICINE

❑ Biliary (HIDA)
❑ Renal Scan
❑ Cardiac Blood Pool (MUGA)
❑ Myocardial Stress Test/Rest
❑ Treadmill ❑ Pharmacologic
❑ Gastric Emptying Study (GES)
❑ DAT Scan

Bone Scan: ❑ 3-Phase ❑ Limited ❑ SPECT
Area of concern: ____________
❑ Whole Body
Thyroid:
❑ Uptake & Scan
❑ Other (specify) ____________

CT SCAN

❑ Head
❑ Neck
❑ C-Spine
❑ T-Spine
❑ L-Spine
❑ Scoliosis
❑ CT Urogram

❑ Chest
❑ Ltd. Sinus

❑ Chest
❑ Abdomen
❑ Pelvis
❑ Abdomen & Pelvis
❑ CT KUB
❑ CT Enterography
❑ Other (Specify) ____________

❑ CTA Head
❑ CTA Neck
❑ CTA Chest
❑ CTA Abdomen
❑ CTA Abdomen & Pelvis
❑ CTA Pelvis
❑ Other (Specify) ____________

MRI SCAN

❑ **No Contrast** ❑ **Contrast at radiologist discretion**
❑ **Patient has a Pacemaker / or Implanted Device**
❑ **Patient may have metal in eye**

❑ Brain
❑ Orbits w/Brain
❑ Face / Neck
❑ C-Spine
❑ L-Spine ❑ T-Spine
❑ Other (Specify) ____________

❑ Abdomen
❑ Pelvis
❑ Enterography
❑ MRCP
❑ MRA (Specify) ____________

Extremity
❑ W / Joint Arthrogram
lt **rt** ❑ Hand
lt **rt** ❑ Wrist
lt **rt** ❑ Elbow
lt **rt** ❑ Shoulder
lt **rt** ❑ Hip
lt **rt** ❑ Knee
lt **rt** ❑ Ankle
lt **rt** ❑ Foot
lt **rt** ❑ Other (Specify) ____________

INJECTIONS & PROCEDURES

❑ Diagnostic & Therapeutic Injection (Specify) ____________
❑ Interventional Procedure (Specify) ____________

Referring Provider Signature *(required for exam):* ____________

PRIOR EXAMS

____________ ____________
Date of Service Facility Location

Other Last Name ____________

Appointment:

Date: ______ Check-in Time: ______

Appointment Time: ____________

❑ Call patient to schedule
❑ Patient will call to schedule

Reports:

❑ Call STAT: ____________
❑ Fax STAT: ____________
❑ Fax Routine: ____________

Images: ❑ CD ROM ❑ Web PACS
❑ Send with patient ❑ Send to provider

Additional Reports to PCP:

____

Insurance(s): ____________
Pre-Authorization #: ____________
Injury Date: ____________
Claim #: ____________

Scheduling:
Phone: 253.792.6220 • Toll Free: 866.268.7223
Fax: 253.792.6230

MultiCare Medical Imaging Locations

AUBURN

MultiCare Auburn Health Center
202 Cross St. SE Auburn, WA 98002
Phone: 253.792.6220 • Fax: 253.792.6230

Auburn Diagnostic Imaging Services
125 3rd St. NE # 300 Auburn, WA 98002
Phone: 253.886.5307 • Fax: 253.886.5326

Auburn Medical Center
202 N Division St. Auburn, WA 98001
Phone: 253.792.6220 • Fax: 253.792.6230

BONNEY LAKE

Diagnostic Imaging Northwest
21110 SR 410 East, Suite 110, Bonney Lake, WA 98391
Phone 253.841.4353 • Fax 253.446.3973

Diagnostic Imaging Northwest
10004 - 204th Ave East, Suite 2600, Bonney Lake, WA 98391
Phone 253.841.4353 • Fax 253.446.3973

COVINGTON

MultiCare Covington Clinic
17700 S.E. 272nd St., Suite 145 Covington, WA 98042
Phone: 253.792.6220 • Fax: 253.792.6230

GIG HARBOR

MultiCare Gig Harbor Medical Park
4545 Pt. Fosdick Dr. NW, Suite 135, Gig Harbor, WA 98335
Phone 253.792.6220, Toll free 866.268.7223
Fax 253.792.6230

KENT

MultiCare Kent Clinic
222 State Ave. N. Kent, WA 98030-4544
Phone: 253.792.6220 • Fax: 253.792.6230

PUYALLUP

Diagnostic Imaging Northwest
222 15th Avenue Southeast, Puyallup, WA 98372
Phone 253.841.4353 • Fax 253.446.3973

Diagnostic Imaging Northwest
11212 Sunrise Blvd. East, Suite 200, Puyallup, WA 98374
Phone 253.841.4353 • Fax 253.446.3973

Good Samaritan Hospital
401 15th Avenue Southeast, Puyallup WA, 98371
Phone 253.792,6220, Toll free 866.268.7223
Fax 253.792.6230

TACOMA

Allenmore Medical Center
Hospital: 1901 South Union Avenue, Tacoma, WA 98405
Phone 253.792.6220, Toll free 866.268.7223
Fax 253.792.6230
C Building: 3124 So. 19th Street, Suite 100, Tacoma, WA 98405
253.792.6220, Toll free 866.268.7223 • Fax 253.792.6230

Mary Bridge Children's Health Center
311 South L Street, Tacoma, WA 98405
Phone: 253.403.9152 • Fax: 253.403.9153

MultiCare Tacoma General Hospital
& Mary Bridge Children's Hospital
315 Martin Luther King, Jr. Way, 3L, Tacoma, WA 98405
Phone 253.792.6220, Toll free 866.268.7223
Fax 253.792.6230

Carol Milgard Breast Center
4252 S. 19th St. Tacoma, WA 98405
Phone: 253.759.2622, Toll free 866.758.2622
Fax: 253.572.4324