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

Date of Referral:_____ Referring Provider Name: _____

Patient Name: _____(first) _____(MI) _____(last)

D.O.B.: _____-_____-_____ Patient Phone #: (_____) _____-_____ (home) (_____) _____-_____ (work or cell)

**Written Diagnosis/Reason/ICD-9/Symptoms for Exam(s) – REQUIRED**

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. **Rule out, Possible or Probable Conditions cannot be coded**. For Medicare Policy information see the Part B Bulletin or www.noridian.com/medweb.

**NOTES**: Height_____ Weight_____ GFR/Creatinine (current, within 8 weeks) _____/ _____

Allergies: _____

## SPECIALTY EXAMS

**NUCLEAR MEDICINE** (Covington):

❑ Billiary (HIDA)
❑ Renal Scan
❑ Cardiac Blood Pool (MUGA)
❑ Myocardial Stress Test and Rest
❑ Treadmill ❑ Adenosine
❑ Gastric Emptying Study (GES)

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

**CT Scan (Contrast* & 3D Reconstruction as clinically indicated by radiologist); or ___ no contrast** (Auburn/Covington):

❑ Head
❑ Sinuses
❑ Ltd. Sinuses
❑ Neck
❑ C-spine
❑ T-spine
❑ L-spine

❑ CT KUB
❑ Chest
❑ Abdomen
❑ Abdomen & Pelvis
❑ Pelvis
❑ CT Appy
❑ Other (Specify):_____

❑ CTA Head & Neck
❑ CTA Chest
❑ CTA Abdomen
❑ CTA Abdomen & Pelvis
❑ CTA Pelvis
❑ CTA Other (specify)

**MRI Exam (Contrast* & 3D Reconstruction as clinically indicated by radiologist); or ___ no contrast** (Auburn/Covington):

❑ Head_____
❑ Thyroid/Larynx
❑ C-spine
❑ T-spine
❑ L-spine
❑ Soft tissue (specify):
_____
_____

**Extremity Joint**

❑ w/joint arthrogram
Lt Rt ❑ Wrist
Lt Rt ❑ Elbow
Lt Rt ❑ Shoulder
Lt Rt ❑ Knee
Lt Rt ❑ Ankle
Lt Rt ❑ Foot
Lt Rt ❑ Other (specify):_____

❑ Abdomen
❑ MRCP
❑ MRA (specify):
_____
_____

** If the MRI / CT exam is ordered "with contrast," GFR/Creatinine/results may be requested prior to exam.*

**PRIOR EXAMS:**

_____ _____
Date of Service Facility Location

## APPOINTMENTS:

**Exam:** _____

M T W T F S Sn
Date:_____-_____- _____
Time: _____

**Exam:** _____

M T W T F S Sn
Date:_____-_____- _____
Time: _____

❑ Call patient to schedule
❑ Patient will call to schedule
❑ Call Results STAT: (_____) _____
❑ Fax Results STAT:(_____) _____
❑ Fax Results Routine: (_____) _____
Return Patient to the office w/films
Send ❑ CD ROM ❑ Films

**Additional reports to**:

_____
PCP: _____

**PCP authorization #** (if needed):

_____

**Insurance authorization #** (if needed):

_____

**Name of Insurance is Required:**

_____

**Referring Provider Signature (Required for Exam):**_____



**Fax: 253-372-7236**

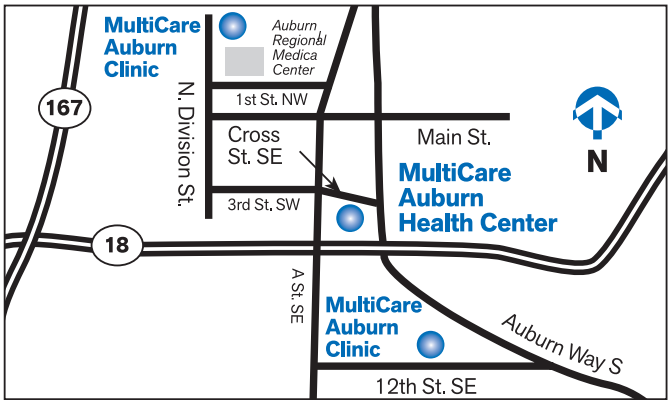
# SKC SPECIALTY IMAGING EXAM/REFERRAL FORM

MultiCare

87-????-? (7/09)

## Directions to the MultiCare Auburn Health Center:

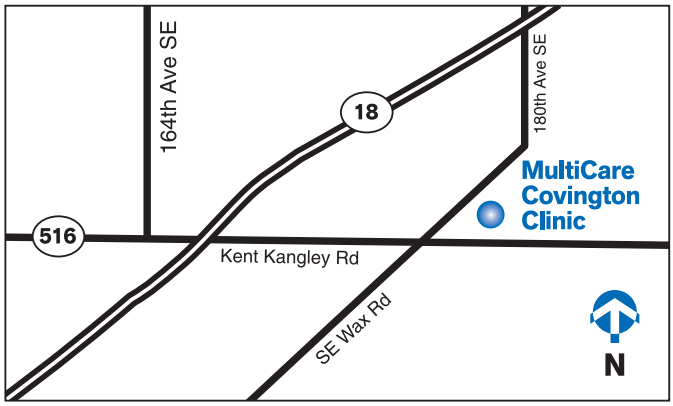
The Auburn MultiCare Health Center is located at 202 Cross Street SE, near downtown Auburn. From Highway 18, take the Auburn Way exit. Turn right onto Auburn Way. Go under the highway and at the first stoplight, turn left onto Cross Street . The Auburn MultiCare Health Center will be on your left.




**MultiCare Auburn Health Center**
**202 Cross Street SE • Auburn WA 98002**
**Phone: 253-876-8190**
**Scheduling: 253-372-7228**
**Fax: 253-372-7236**

## Directions to the MultiCare Covington Clinic:

From I-5, take Highway 18 east and exit at the SE 272nd St./Highway 516 exit. Turn right at the stoplight and continue to SE Wax Road. Turn left. The Covington MultiCare Clinic entrance is off SE Wax Road on the right.




**MultiCare Covington Clinic Imaging**
**17700 SE 272nd St., Suite 145 • Covington WA 98042**
**Phone: 253-372-7040**
**Scheduling: 253-372-7228**
**Fax: 253-372-7236**