

## SWEDISH MEDICAL IMAGING

### SWEDISH ISSAQUAH GENERAL IMAGING REQUISITION FORM

Phone: 425-313-5400 • Fax: 425-313-5401 • 751 NE Blakely Drive, Issaquah, WA 98029

Today's date: \_\_\_\_\_

#### Patient information: (All fields are required)

Patient legal name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Patient phone number: \_\_\_\_\_  Male  Female  Other: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Call patient to schedule  Need interpreter (language): \_\_\_\_\_ Need assistive:  Hearing  Visual device  
**Pregnant?**  Yes  No **Diabetic?**  Yes  No **Allergies?**  Contrast  Iodine  Latex  Other: \_\_\_\_\_  
 Insurance/Plan: \_\_\_\_\_ Member #/ID: \_\_\_\_\_  Uninsured  Self-pay  
 Authorization #: \_\_\_\_\_ Valid date(s): \_\_\_\_\_  L & I, Claim #: \_\_\_\_\_

#### Ordering provider: (All fields are required)

Physician printed name: \_\_\_\_\_ NPI: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature: (required) \_\_\_\_\_ Date/Time: \_\_\_\_\_  
 Clinic contact: \_\_\_\_\_ Clinic fax: \_\_\_\_\_  
 In event of critical finding, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Reason for exam: (All fields are required)

ASAP  Routine Symptoms/Diagnosis: \_\_\_\_\_  
 Reason for exam: \_\_\_\_\_  
 ICD-10: \_\_\_\_\_ CPT code(s): \_\_\_\_\_

**Reports are always faxed.**  Fax **additional** report to: Dr. \_\_\_\_\_ Fax: \_\_\_\_\_  
 Prior films?  No  Yes, where? \_\_\_\_\_ If injured, date of injury: \_\_\_\_\_  
 Swedish Image Transfer Request Form: <https://www.swedish.org/services/medical-imaging/image-transfer-request>  
 Comments/Instructions: \_\_\_\_\_

**Decision support** Vendor (G code) \_\_\_\_\_ Adherence code (M modifier) \_\_\_\_\_ ID \_\_\_\_\_ Score \_\_\_\_\_

#### Exam ordered: (Patient preps and directions on back)

Does patient have any implants?  No  Yes, what and where \_\_\_\_\_  
 If ordering MR or CT: **IV contrast?**  With  Without  Without and with **Creatinine:** \_\_\_\_\_ Date: \_\_\_\_\_

MRI	CT	Ultrasound	X-ray
<input type="checkbox"/> Brain <input type="checkbox"/> Soft tissue neck Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Abd <input type="checkbox"/> Pelvis (screening) <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> MRCP (biliary) <input type="checkbox"/> Adrenal <input type="checkbox"/> Female pelvis <input type="checkbox"/> MSK pelvis <input type="checkbox"/> MR IVP (renal mass) <input type="checkbox"/> TMJ <input type="checkbox"/> Brain MRA <input type="checkbox"/> Neck MRA (carotids) <input type="checkbox"/> Chest MRA <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis MRA <input type="checkbox"/> Extremity / Other MRI: _____ _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arthrogram	<input type="checkbox"/> Head <input type="checkbox"/> Sinus <input type="checkbox"/> Soft tissue neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Adrenal <input type="checkbox"/> CT IVP (renal mass) <input type="checkbox"/> CT KUB (renal stone) <input type="checkbox"/> Head <input type="checkbox"/> Neck CTA <input type="checkbox"/> Pulmonary CTA (PE) <input type="checkbox"/> CT Aortogram _____ <input type="checkbox"/> Coronary CTA <input type="checkbox"/> Cardiac CA Scoring <input type="checkbox"/> Extremity / Other MRI: _____ _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arthrogram	<input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Gallbladder <input type="checkbox"/> Appendix <input type="checkbox"/> Kidney/Bladder <input type="checkbox"/> Scrotum <input type="checkbox"/> Aorta <input type="checkbox"/> Soft tissue mass _____ <input type="checkbox"/> Hernia _____ <input type="checkbox"/> Thyroid <input type="checkbox"/> Obstetric <input type="checkbox"/> W <input type="checkbox"/> WO TV <input type="checkbox"/> Biophysical profile <input type="checkbox"/> Nuchal trans w/bloodwork <input type="checkbox"/> Neonatal hips <input type="checkbox"/> Other ultrasound: _____ _____	<input type="checkbox"/> Chest <input type="checkbox"/> Scoliosis <input type="checkbox"/> Abdomen <input type="checkbox"/> Leg length <input type="checkbox"/> Pelvis <input type="checkbox"/> Bone age <input type="checkbox"/> Ribs <input type="checkbox"/> Sinus Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Extremity / Other X-ray: _____ _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wt-bearing <div style="background-color: black; color: white; padding: 2px; margin-top: 5px;"><b>Fluoroscopy</b></div> <input type="checkbox"/> Barium swallow <input type="checkbox"/> Modified <input type="checkbox"/> Upper GI <input type="checkbox"/> Small bowel FT <input type="checkbox"/> Arthrogram <input type="checkbox"/> Barium enema <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Cystogram (VCUG) <input type="checkbox"/> Other fluoro: _____

**Please use a separate order form for the following:** Breast Imaging (Mammo, Bx, Breast US & MR);  
 Interventional (Angio, Bx, Drainage, Ablation); DEXA Scan (Bone Densitometry); Nuclear Medicine/PETCT

**Please fax order to: 425-313-5401. Thank you for choosing Swedish!**

# PATIENT INSTRUCTIONS

## MRI

Our short-length, wide bore MRI scanner is a very comfortable scanner. Moreover, it offers very high image quality. We also let you select your own music for your scan to increase your comfort level.

MRI scanners do not use radiation.

Please arrive 15 minutes before your exam. Patients should wear metal-free clothing or a hospital gown. Please remove all jewelry, watches, piercings, etc. There may be eating or drinking restrictions.

If you are claustrophobic, medication may be taken (as prescribed by your ordering physician). You must have a ride to and from your appointment.

### Does patient have?

Pacemaker/Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ferromagnetic prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ferromagnetic aneurysm clip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other implanted device	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal anywhere in body	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattoo/Body piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ortho pins/screws/rods/joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## CT

Our 128-detector CT scanner technology delivers faster scanning and up to 40% less radiation dose than traditional CT scanners. We use detailed protocols and other techniques to ensure your radiation dose is as low as possible.

Do not eat or drink for four hours prior to your exam. If you are receiving oral contrast, please arrive two hours before your exam. Otherwise, please arrive 15 minutes prior to your exam.

## ULTRASOUND

Our state-of-the-art equipment produces very clear 3D digital images using sound waves (no radiation).

Please arrive 15 minutes before your exam.

- For **abdomen studies**, do not eat or drink for 8 hours prior to your exam (except sips of water with necessary medications).
- For **kidney studies**, drink three 8 ounce glasses of water 1 hour before your exam and keep your bladder full.
- For **pelvis studies**, drink three 8 ounce glasses of water 1 hour before your exam and keep your bladder full.
- For **pregnancies in the first 14 weeks**, drink three 8 ounce glasses of water 1 hour before your exam and keep your bladder full. For pregnancies after the first 14 weeks it is not necessary to have a full bladder.

## X-RAY AND FLUOROSCOPY

We accept walk-ins for X-ray.

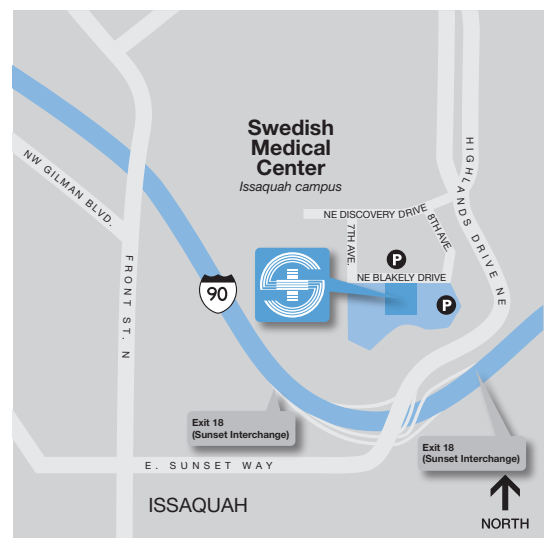
Please contact our department for patient instructions for all fluoroscopy exams.

## Directions and map to Swedish Issaquah campus

### Traveling from I-90:

- Take the E. Sunset Way/Highlands Drive exit — Exit 18.
- If traveling east, go left at the "Y" and continue on Highlands Drive.
- If traveling west, turn right (north) onto Highlands Drive.
- At the next light, turn left (west) onto NE Discovery Drive.
- Take first left onto 8th Avenue.
- Go straight into the main parking lot or right into underground parking.

**All patient parking is convenient and free.** Medical Imaging is located on the first floor of the Cascade (East) wing.



## SWEDISH MEDICAL IMAGING

### Issaquah

751 NE Blakely Drive  
1st Floor, Cascade (East) Wing  
Issaquah, WA 98029  
T 425-313-5400  
F 425-313-5401

[swedish.org/services/medical-imaging](http://swedish.org/services/medical-imaging)

We do not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity or expression, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY:711)

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 888-311-9127 (TTY:711)

