

OLYMPIC RADIOLOGY ASSOCIATES INC. PS

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Request for Imaging Consultation

Patient Name _____ Date of Birth _____

M _____ F _____ APPOINTMENT: Day _____ Date _____ Time _____

Exam Requested: _____

Reason for Request: _____

Provisional Diagnosis or Symptoms: _____

Referring Practitioner _____ Copy of Report to: _____

Comparison Exams at: _____

_____ Stat Read _____ Call Report _____ Send Films with Patient _____ Films via courier _____ Fax Report

Please circle any that apply:

MRI

with contrast if clinically indicated

Brain
IAC Screen
Orbit
TMJ
Neck
Spine C T L
Extremity R L _____
Joint R L _____
Chest
Abdomen MRCP
Pelvis
MRA: Circle of Willis
Carotids
Renal
Run Off

NUC MED

Bone Scan Ltd. _____
w/spect
Whole Body
Gastric Emptying
Hepatobiliary (HIDA)
Liver-Spleen
Lung-Vent / Perf (VQ)
Renal
Thyroid-Uptake / Scan

CT

with contrast if clinically indicated

Head
Facial
w/3D Recon/Reformat
Sinus
Complete Coronal or Screen
Temporal Bone
Orbit
Neck
Chest Chest - P.E.
Chest thru Liver (LTD.)
Abdomen
Pelvis
CT KUB
Spine C T L
w/3D Recon/Reformat
Extremity R L _____
w/3D Recon/Reformat
Joint R L _____
w/3D Recon/Reformat
CTA: Chest
Renal
Aorta - Thoracic
- Abdominal

US

Abdomen
Renal
Aorta
Pelvis
OB
Neonatal Head
Infant Hips
Thyroid
Breast
Scrotum
Vascular
Carotid _____
Venous _____
Hysterosonogram (Saline Infused)

X-RAY

Chest Ribs KUB
Acute Abdomen
Spine C T L
Extremity R L _____
Joint R L _____
Bone Survey
Head: Skull Sinus
Face Orbit Mandible
Scoliosis

FLUORO

Barium Enema
UGI
Esophagus
Small Bowel
IVP
VCUG
Arthrogram R L _____
Myelogram C T L
Hysterosalpingogram
Venogram
Fistulogram
Video Swallowing

SPECIAL PROCEDURES

Biopsy _____
Thoracentesis _____
Paracentesis _____
Aspiration _____
Injection _____
Lumbar Puncture _____

PLEASE TURN OVER  FOR PATIENT INSTRUCTIONS

Please present this form to Olympic Radiology at time of your appointment.