101 NW 12th Ave STE 107
Battle Ground, WA 98604

Phone: 360.583.4636
Fax: 360.995.0081

PATIENT INFORMATION

Patient First Name: _____

Patient Last Name: _____

Patient Phone: _____

Date of Birth: _____ Gender: M F

Mailing Address: _____

☐ Patient will call to schedule ☐ Please call patient

Insurance: _____

PRIOR AUTHORIZATION #: _____

Any Prior Imaging: Y N If yes, what imaging and where was it done:

_____

REQUESTING PROVIDER INFORMATION

Referring Provider _____

Referring Provider's NPI: _____

Phone (to clarify orders) _____

Date _____ Fax _____

Provider Signature _____

Optional (check all that apply):

☐ STAT ☐ CD with Images

☐ Email Report (email address) ☐ Phone Report (phone number)

_____ _____

☐ Fax Report (fax number) ☐ Special Request

_____ _____

Diagnosis/ ICD (REQUIRED): _____

XRAY

OF VIEWS_____

__R __L __BIL

__Chest PA and LAT
__Ribs PA Chest
__Clavicle
__Abdomen KUB
__Acute Abdomen Series
__Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Scoliosis

__Pelvis
__SI Joints
__Sacrum/Coccyx
__Hip
__Other: _____
__Upper Extremity
- ☐ Shoulder
- ☐ Humerus
- ☐ Elbow
- ☐ Forearm

☐ Wrist
☐ Hand
☐ Finger(s) _____
__Lower Extremity
- ☐ Femur
- ☐ Knee
- ☐ Tib/Fib
- ☐ Ankle
- ☐ Foot
- ☐ Toe(s) _____

ULTRASOUND

__R __L __BIL

__Thyroid
__Head/Neck Soft Tissue
__Abdomen
- ☐ Complete
- ☐ RUQ
- ☐ LUQ
- ☐ Aorta

__Abdomen Doppler
__Appendix
__Renal __Renal Artery
__Bladder pre/post void
__Pelvis - Transvaginal
__Pelvis - Transabdominal
__OB
- ☐ Trimester 1 2 3
- ☐ Transvaginal *if indicated

__Hernia
- ☐ Inguinal ☐ Umbilical

__Scrotum
__Carotid
__Lower Venous
__Upper Venous
__Lower Arterial Doppler
__Upper Arterial Doppler
__MSK __Soft Tissue
__Other: _____

CT SCAN

__R __L __BIL

☐ W/ Contrast ☐ W/O Contrast

__Head
- ☐ Sinus
- ☐ Orbits
- ☐ Facial Bones
- ☐ IAC

__Soft Tissue Neck
__Chest
__Chest/Abd/Pelvis
__Chest/Abd
__Abdomen
__Abdomen/Pelvis
__Pelvis
__Urogram
__Renal Colic/KUB
__Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

__Extremity: _____
__Other: _____
_____

CT ANGIOGRAM

__R __L __BIL

__CTA Abdomen
- ☐ Pancreas
- ☐ Adrenal
- ☐ Liver protocol

__CTA Head
__CTA Chest
- ☐ PE
- ☐ Aorta

__CTA Neck
__CTA Abdomen/Pelvis
__CTA Lower Ext Runoff
__Other: _____

Please call if you have questions about your insurance coverage or our self pay prices

www.vitalcarewa.com