

RADIOLOGY REFERRAL FORM- COMMON

Date: _____ Referring Provider: _____

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

Phone: (____) ____ - _____ Interpreter needed *(language)*: _____

Notes: Height _____ Weight _____ Pregnant Yes No Allergies: _____

Clinical History/Signs & Symptoms **REQUIRED:**

Signs/Symptoms: _____ Duration: _____

Cause (Hx, Trauma, etc.): _____ Area: _____

Is this due to an injury? Yes No If so, please specify: MVA LNI DOI: _____

Appointment

Date: _____ - _____ - _____ Time: _____:_____

Call patient to schedule Patient will call to schedule

Prior Exams:

Date of Service _____ Facility Location _____

Report

Call STAT (____) _____ - _____

Fax STAT (____) _____ - _____

Fax Routine (____) _____ - _____

Additional Report To: _____

Images: CD ROM Deliver to my office

Web PACS Send with patient

Insurance Information

Send copy of patient's insurance card when faxing this referral.

Insurance(s) _____

Claim # _____

(if applicable)

Pre-Authorization # _____

LOCATIONS & SCHEDULING

Pierce County

TRA Tacoma- on Cedar

TRA Gig Harbor

TRA Tacoma- on Hilltop

TRA Lakewood

Thurston County

TRA Olympia - on Lilly

TRA Lacey- Corporate Center

Pierce Scheduling

Phone: (253) 761-4200

Fax: (253) 761-4201

Thurston Scheduling

Phone: (360) 413-8383

Fax: (360) 413-8323

Toll-Free: (866) 761-4200

Tax ID

TRA: 91-0979582

www.tranow.com

X-RAY No appointment required. Specify additional views:

Sinuses _____

Chest _____

Cervical Spine _____

Thoracic Spine _____

Lumbar Spine _____

Scoliosis _____

KUB _____

Abdomen Series _____

Pelvis only _____

Pelvis w/Lateral Hip _____

Hip _____ lt rt bilat

Shoulder _____ lt rt bilat

Ribs _____ lt rt bilat

Elbow _____ lt rt bilat

Forearm _____ lt rt bilat

Wrist _____ lt rt bilat

Hand _____ lt rt bilat

Finger _____ lt rt bilat

Knee _____ lt rt bilat

Tib/Fib _____ lt rt bilat

Ankle _____ lt rt bilat

Foot _____ lt rt bilat

Toe _____ lt rt bilat

Other _____

ULTRASOUND

Thyroid _____

Vascular _____

AAA Screen *(Medicare only- once a lifetime)*

Abdomen-Complete _____

Abdomen-Limited _____

Extremity-Limited _____

Hernia protocol _____

Renal _____

Pelvic *(transabdominal &/or transvaginal as needed for diagnostic visualization)*

Pelvic transvaginal only _____

OB LMP _____

Multiple High Risk Follow-up

< 14 weeks complete *(transvaginal as needed for visualization)*

> 14 weeks complete

OB Biophysical Profile _____

Testicular _____

Other _____

BONE DENSITOMETRY (DEXA)

Spine & Femur _____

Other: _____

BREAST IMAGING Diagnostic & Ultrasound imaging ONLY offered at TRA Olympia- on Lilly

Date of last Mammogram: _____

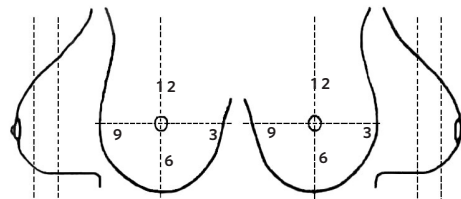
Screening *(asymptomatic)* Uni Bilat

Diagnostic *(symptomatic)* Uni Bilat *(ultrasound if needed &/or recommended)*

Ultrasound _____ lt rt bilat

Document Palp Abn: _____

O'clock: _____ N+ _____



FLUOROSCOPY Offered at TRA-on Cedar & TRA Olympia-on Lilly ONLY

HSG _____

HSG- ESSURE _____

Other: _____

Referring Provider Signature _____
Required for exam

Locations

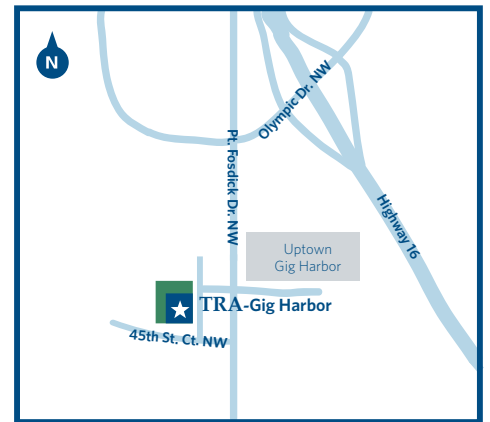
For directions, please visit our website: www.tranow.com



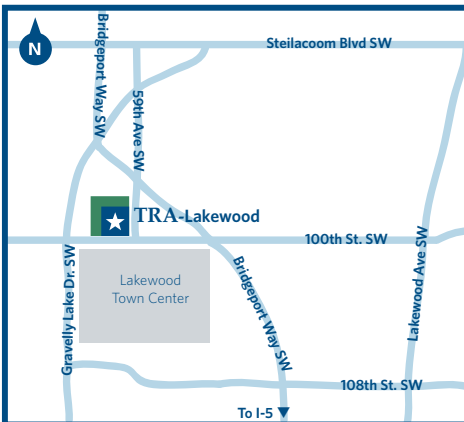
TRA- Tacoma on Cedar
2202 South Cedar St, Suite 200
Tacoma, WA 98405



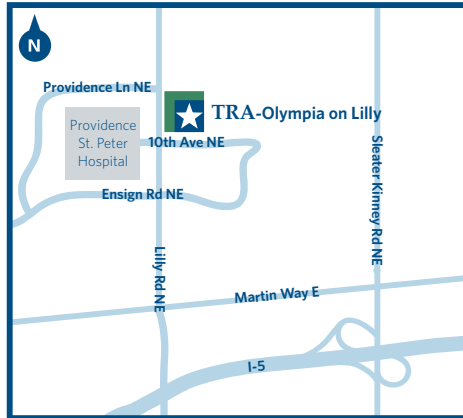
TRA- Tacoma on Hilltop
1202 MLK Jr Way, Suite 140
Tacoma, WA 98405



TRA Gig Harbor
4700 Point Fosdick Drive NW, Suite 110
Gig Harbor, WA 98335



TRA Lakewood
5919 100th St SW
Lakewood, WA 98499



TRA Olympia - on Lilly
500 Lilly Road NE, Suite 160
Olympia, WA 98506



TRA Lacey at Corporate Center
5210 Corporate Center Ct SE, #C
Lacey, WA 98503