RADIOLOGY REQUEST FORM: All Applicable Fields are Required to Process Request

Circle Exam(s) Desired: Angio Radiology Ultrasound Nuclear Medicine CT MRI

FAX Top Copy of Request to:	**Inpatient 4-2295**	**Portables 4-2242**	**Outpatient 4-8206**	**NucMed 4-8232**	**Angio 4-8116**

Clinic or Unit/Room #	Date of Request	Transportation: Walk, Wheelchair, Stretcher, Bed (circle) Risk of Fall Yes ☐ No ☐

Exam(s) Requested:	**Diagnosis; Signs and Symptoms; or Mechanism (Medical Necessity):** **Separate medical necessity is required for each exam ordered**
1.	**1.**
2.	**2.**
3.	**3.**

Requestor/Ordering Provider:	**UWP #**	**Phone/Pager #**
Attending Physician (if different from Requester)	UWP #	Phone/Pager #
Person filling out request (if different from either of the above)		Phone/Pager #

Priority:
☐ STAT
☐ Urgent
☐ Discharge
☐ Routine

PRECAUTIONS:
☐ Pregnant ☐ Spine/Traction ☐ Recent Barium Study ☐ If > 275 lbs. record weight _____
☐ Restraints ☐ Diabetes ☐ Isolation _____ ☐ Allergies _____
☐ Requires a Sitter ☐ Other: _____

☐ Male ☐ Female Age _____ Height _____ Weight _____	☐ Interpreter Language:	Insurance information

Complete for Angio Interventional:
PT _____INR_____
PTT _____
Hematocrit _____
Platelet Count _____
Creatinine_____

Complete for CT/MR/ Angio Contrast Studies:
☐ IV ☐ Oral
☐ Rectal
Contrast Allergy
☐ Yes ☐ No
Creatinine_____
Date of Creatinine:

Complete for Nuclear Medicine:
List Meds & Doses

Complete for MRI:

Sedation Needed	☐ Yes	☐ No	Cerebral Aneurysm
Metal Worker (ever)	☐ Yes	☐ No	Clips ☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Type _____
Neuro Stimulator	☐ Yes	☐ No	Date _____
Cochlear Implant	☐ Yes	☐ No	
Swan/EPI Cath	☐ Yes	☐ No	
Bullets	☐ Yes	☐ No	

FOR RADIOLOGY USE ONLY

SCANNING PARAMETERS:	ACCESSION NUMBER:

PT. NO.

NAME

Place EPIC Label Within Box

D.O.B.

UW Medicine
Harborview Medical Center - UW Medical Center
University of Washington Physicians
Seattle, Washington
DIAGNOSTIC IMAGING PHYS ORD - OUTPT

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WHITE - RADIOLOGY
WHITE - MEDICAL RECORD