PACIFIC WEST
DIAGNOSTIC IMAGING

643 Strander Blvd Tukwila, WA 98188
(425) 654-0887

Physician Referral Form

To schedule an appointment Fax: (425) 209-0091

PATIENT INFORMATION

____MRI ____X-Ray Requested Date:_____

Patient Legal Name: _____(last), _____(first) Gender: ☐ F | ☐ M

Date of Birth: _____ Height/Weight: _____ Phone Number:_____

Ordering Physician: _____ Physician Signature:_____

Office name: _____ Phone #: _____ Fax #:_____

Attorney: _____

Office name: _____ Phone #: _____ Fax #: _____

Insurance: _____ Policy/Claim Number: _____

Claim Adjuster Phone #: _____ Date Of Injury: _____

Physician Preference for Results: ☐ Report Only ☐ Report and CD ☐ Routine ☐ Stat
☐Fax:_____ ☐Other:_____

ICD -10 Code(s):_____

Symptoms:_____

BODY PART

Brain
☐ Brain & Pituitary ☐ Face ☐ Orbits ☐ Pituitary ☐ Sinus ☐ TMJ

Body
☐ Abdomen ☐Breast ☐ Chest ☐ Cholangiogram (MRCP) ☐ Pelvis

Spine
☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Sacrum/Coccyx ☐ SI Joints

☐ Knee	☐ Right	☐ Left	
☐ Ankle	☐ Right	☐ Left	
☐ Hip	☐ Right	☐ Left	
☐ Wrist	☐ Right	☐ Left	
☐ Elbow	☐ Right	☐ Left	
☐ Shoulder	☐ Right	☐ Left	

Check box if:
- ☐ Claustrophobic
- ☐ Metal in body/eyes
- ☐ Stents or Shunts
- ☐ Aneurism Clips
- ☐ Sedation required **All patients receiving sedation require drive*

Received Order Date:_____

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