RADIOLOGY REQUEST

Wenatchee Radiology .....Fax: 509-436-3001
East Wenatchee Radiology.....Fax: 509-665-5812
Moses Lake Radiology.....Fax: 509-764-6464
Omak Radiology .....Fax: 509-826-7915
Central Washington Hospital.....Fax: 509-662-7054

Patient information:

Last Name:_____ First Name:_____ DOB:_____

Patient phone:_____ Cell: _____

Exam: _____

___with IV contrast; ___without IV contrast; ___with AND without IV contrast; ___ arthrogram

History, symptoms or diagnosis: _____

_____

ICD code _____ CPT code: _____

Creatinine:_____ Date drawn:_____

(Creatinine blood test needed within the last 30 days if ≥ 60 years old, diabetic or kidney disease.)

Notes: _____

Insurance:_____ Authorization #:_____Expires:_____

L and I Claim #:_____ DOI: _____

Referring physician/ fax: _____

Preferred day/time: _____ Interpreter needed? ☐Yes ☐No

Physician: _____ Physician Signature:_____ *(REQUIRED)*

Physician Phone:_____ Date:_____ *(REQUIRED)* Time:_____ *(REQUIRED)*

To be completed by Confluence Health Radiology:

Appointment date/ time: _____