RADIOLOGY REQUEST

Wenatchee Radiology Fax: 509 664 3443
East Wenatchee Radiology Fax: 509 665 5801
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:_____ Time:_____

To be completed by Confluence Health Radiology:

Appointment date/ time: _____

Revised: 3/16