



RADIOLOGY REQUEST

Wenatchee RadiologyFax: 509-436-3001
East Wenatchee Radiology.....Fax: 509-665-5812
Moses Lake RadiologyFax: 509-764-6464
Omak RadiologyFax: 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: _____