SOUTH SOUND
FAMILY & SPORTS MEDICINE

2960 Limited Lane NW, Ste A
Olympia, WA 98502
FOR APPOINTMENTS CALL
360-709-9500

RADIOLOGY REFERRAL

referral required @ appointment time

FOR PROVIDER USE ONLY

Patient ID # _____ Exam Date ___/___/___ (M / D / Y) Exam Time _____ am / pm

Patient Name _____
(please print) First M Last

Gender : Male ☐ Female ☐ D.O.B _____/_____/_____ (Month / Day / Year) SSI # _____-_____-_____

Phone Number _____-_____-_____ Alt Phone Number _____-_____-_____ ☐Cell ☐ Message

☐ Make Available on Secure FTP

☐ Patient to return W/ study CD

Insurance Auth. (If needed) _____

Provider Signature: _____

Examination Requested:

Study ID # _____ Accession # _____

Clinical History: HX / DX / Symptoms

_____

Upper Extremities:

☐ -- **Shoulder** --------- AP ☐ --------- Axial ☐ --------- Trans ☐ ☐ -- **Scapula**
☐ – **Humerus** ☐ – **Forearm** ☐ – **Clavicle** ☐ – **Hand**
☐ -- **Wrist** ---------- AP ☐ ---------- Lateral ☐ ☐ – **Elbow** --------- AP ☐ --------- Lateral ☐

Chest:

☐ -- **Chest** --------- PA ☐ --------- AP ☐ --------- Lateral ☐ ☐ -- **Chest** (First Year) ------- AP ☐ --------- Lateral ☐
☐ -- **Chest** (Pediatric) ------- AP ☐ --------- Lateral ☐ ☐ -- **Ribs** -------- Upper ☐ --------- Lower ☐
☐ -- **Sternum**

Abdomen:

☐ -- **Abdomen** ------- AP ☐ ------- PA ☐

Spine:

☐ -- **C Spine** --------- AP ☐ --------- Lateral ☐ --------- Open Mouth ☐ ☐ -- **C Spine Pediatric**
☐ -- **C Spine** --------- Phaynx / Larynx ☐ ------- Swimmers ☐ ☐ -- **T Spine** --------- AP ☐ --------- Lateral ☐
☐ -- **L Spine** --------- AP ☐ --------- Lateral ☐ ☐ -- **Full Spine** --------- Lateral ☐ --------- AP ☐
☐ -- **Sacrum / Coccyx** ☐ -- **Pelvis**

Lower Extremities:

☐ -- **Hip** --------- AP ☐ --------- Lateral Axial ☐ ☐ -- **Femur** ☐ -- **Knee** --------- AP ☐ --------- Lateral ☐
☐ -- **Patella** ☐ -- **Tibia** ☐ -- **Ankle** --------- AP ☐ --------- Lateral ☐
☐ -- **Clacaneus** ☐ -- **Foot** ☐ -- **Toe** ☐ -- **Full Leg** --------- AP ☐ --------- Lateral ☐