COASTAL IMAGING & VASCULAR ASSOCIATES
A division of Coastal Radiology Associates

"A Better View for a Healthier You"

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Imaging Referral Form

*Please bring this Referral Form to your Appointment

Patient's Name: _____DOB: _____

Patient's Phone Number: _____Appointment Date: _____ Time: _____

Referring Physician: _____Office#_____Fax#_____

Reason for Exam w/ICD-10 Code: _____

ADDITIONAL CLINICAL INFORMATION: _____

_____

If *required* for this study, provide Pre-Authorization Number: _____

RADIOLOGIC EXAMS
- ❑ Acute Abdomen
- ❑ Flat/Upright Abdomen
- ❑ AC Joints
- ❑ Ankle ❑ Rt ❑ Lt
- ❑ Chest (2 Views)
- ❑ Clavicle ❑ Rt ❑ Lt
- ❑ Elbow ❑ Rt ❑ Lt
- ❑ Facial Bones
- ❑ Fingers (3 Views)
- ❑ Foot (3 Views) ❑ Rt ❑ Lt
- ❑ Forearm (2 Views) ❑ Rt ❑ Lt
- ❑ Femur ❑ Rt ❑ Lt
- ❑ Hand ❑ Rt ❑ Lt
- ❑ Hip ❑ Rt ❑ Lt
- ❑ Humerus ❑ Rt ❑ Lt
- ❑ Knee ❑ Rt ❑ Lt
- ❑ KUB
- ❑ Lower Leg ❑ Rt ❑ Lt
- ❑ Mandible
- ❑ Nasal bones
- ❑ Orbits
- ❑ Paranasal Sinuses
- ❑ Pelvis
- ❑ Ribs ❑ Rt ❑ Lt
- ❑ Ribs w/PA Chest
- ❑ Shoulder (2 Views) ❑ Rt ❑ Lt
- ❑ SI Joints
- ❑ Soft Tissue Neck
- ❑ Spine Cervical (5 Views)
- ❑ Spine Cervical Flex/Ext
- ❑ Spine Thoracic (2 Views)
- ❑ Spine Lumbar (5 Views)
- ❑ Spine Lumbar w/Flex/Ext
- ❑ Spine Sacrum/Coccyx
- ❑ Toes (3 Views)
- ❑ Wrist ❑ Rt ❑ Lt

ULTRASOUND EXAMS
- ❑ Abdomen Complete
- ❑ Abdomen Single Organ/Area
- ❑ Aorta
- ❑ Breast
- ❑ Extremity Specify _____ _____
- ❑ Gallbladder
- ❑ Non-OB Pelvis w/ or w/o TV
- ❑ OB w/ or w/o TV
- ❑ Renal
- ❑ Scrotum
- ❑ Thyroid
- ❑ Biopsy of _____
- ❑ Other_____
- ❑ Soft Tissue

VASCULAR EXAMS
- ❑ Carotid
- ❑ Hemodialysis Access
- ❑ Venous Insufficiency
- ❑ Arterial w/ABI Lower Extremity
- ❑ Arterial Upper Extremity
- ❑ Venous ❑ Bilat ❑ Rt ❑ Lt ___ Upper Ext ___ Lower Ext
- ❑ Vein Mapping ❑ Bilat ❑ Rt ❑ Lt ___ Upper Ext ___ Lower Ext
- ❑ ABI Screening

INTERVENTIONAL RADIOLOGY
- ❑ Peripheral Vascular Disease Consult
- ❑ Venous Consult w/Venous Doppler ___ Bilateral ____ Unilateral
- ❑ Kyphoplasty Consult
- ❑ Sclerotherapy
- ❑ Venous Insufficiency Consult (includes Varicose Veins)

WOMEN'S IMAGING SERVICES
- ❑ Screening Mammogram w/3D Tomography if requested ___ Right ___ Left ___ Bilateral
- ❑ Diagnostic Mammogram w/Breast Ultrasound if indicated ___ Right ___ Left ___ Bilateral

Other: _____ _____

*Please provide any previous imaging.
Location of previous images:
_____
_____
_____

Date of last mammogram: _____

Implants: ( ) YES ( ) NO

Physician Signature & Date: (REQUIRED):	CHECK WHICH APPLIES: ( ) ROUTINE ( ) CALL RESULTS

For directions or specific questions about our Cedar Point location, you may contact our Patient Liaison at ext: 4150