

# IN HEALTH IMAGING

www.inhealthimaging.com

**Poulsbo Main Imaging Center**  
North Kitsap Medical Center  
20700 Bond Road NE  
Poulsbo, WA 98370  
(360) 598-3141

**Bremerton Digital X-ray**  
2601 Cherry Ave., Suite 105  
Bremerton, WA 98310  
(360) 627-9024

**Port Orchard Imaging & Women's Screening Center**  
463 Tremont Street W, Suite 130  
Port Orchard, WA 98366  
(360) 876-3141

**Silverdale Digital X-ray**  
Silverdale Medical Center  
10513 Silverdale Way, Suite 105  
Silverdale, WA 98383  
(360) 307-7087

**Central Scheduling Fax**  
(360) 598-3431

## Need Help?

Providers are encouraged to call Dr. Mantred Henne directly at (360) 598-1644 with special clinical or scheduling questions.

### PATIENT INFORMATION

Please bring picture ID and Insurance Card

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Email \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Insurance \_\_\_\_\_ Authorization # & Expiration Date \_\_\_\_\_  
 Today's Date \_\_\_\_\_ Appt Date \_\_\_\_\_ Appt Time \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Office Contact & Phone # \_\_\_\_\_  
**REPORTING**  STAT: Call Report Immediately After Exam Provide Direct Phone # \_\_\_\_\_  
 Routine  Fax # \_\_\_\_\_  Patient to Return with CD  CC To: \_\_\_\_\_  
**Required: Write in or select one of the common procedures listed below and provide symptoms:** \_\_\_\_\_  
 Patient will call to schedule  
 Please call to schedule

ICD10 Codes: \_\_\_\_\_

Signature: \_\_\_\_\_

### EXAM REQUESTED

<p><b>3T MRI Ultra High Field (open bore)</b></p> <p><input type="checkbox"/> Contrast <input type="checkbox"/> No Contrast  <input type="checkbox"/> Radiologist to Decide</p> <p><b>Spine</b></p> <p><input type="checkbox"/> Cervical  <input type="checkbox"/> Thoracic  <input type="checkbox"/> Lumbar  <input type="checkbox"/> Sacrum  <input type="checkbox"/> SI Joints  <input type="checkbox"/> Pain Injection as Needed</p> <p><b>Head &amp; Neck</b></p> <p><input type="checkbox"/> Brain  <input type="checkbox"/> Orbits  <input type="checkbox"/> Pituitary  <input type="checkbox"/> Internal Auditory Canals  <input type="checkbox"/> Soft Tissue Neck</p> <p><b>Body/Trunk</b></p> <p><input type="checkbox"/> Abd / Liver  <input type="checkbox"/> MRCP with Liver  <input type="checkbox"/> MRCP without Liver  <input type="checkbox"/> Pelvis <input type="checkbox"/> Prostate</p> <p><b>Extremity/Joint</b></p> <p><input type="checkbox"/> (Specify) _____  <input type="checkbox"/> Arthrogram</p> <p><b>MR Angiogram (MRA)</b></p> <p><input type="checkbox"/> Brain <input type="checkbox"/> Carotid/Vertebral  <input type="checkbox"/> Abdomen <input type="checkbox"/> Lower Extremity Runoff  <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Thorax</p> <p><b>MR Venogram (MRV)</b></p> <p><input type="checkbox"/> Brain <input type="checkbox"/> Pelvis</p> <p><b>Pain Injections</b></p> <p>ESI <input type="checkbox"/> C _____ <input type="checkbox"/> T _____ <input type="checkbox"/> L _____  <input type="checkbox"/> Lumbar Facet  <input type="checkbox"/> Lumbar Transforaminal Inj.  <input type="checkbox"/> SI Joint <input type="checkbox"/> Shoulder  <input type="checkbox"/> Hip <input type="checkbox"/> AC Joint <input type="checkbox"/> Ankle  <input type="checkbox"/> Knee/Hyaluronic Injection  <input type="checkbox"/> Knee/Steroid  <input type="checkbox"/> Platelet Rich Plasma</p>	<p><b>CT 64-Slice Low Radiation</b></p> <p><input type="checkbox"/> Contrast <input type="checkbox"/> No Contrast  <input type="checkbox"/> Radiologist to Decide  <input type="checkbox"/> 3D as Needed</p> <p><b>Head &amp; Neck</b></p> <p><input type="checkbox"/> Brain  <input type="checkbox"/> Facial Bones  <input type="checkbox"/> Orbits  <input type="checkbox"/> Sinus  <input type="checkbox"/> Soft Tissue Neck  <input type="checkbox"/> Temporal Bones</p> <p><b>Body/Trunk</b></p> <p><input type="checkbox"/> Chest  <input type="checkbox"/> Low Dose Lung Cancer Screening  <input type="checkbox"/> Abdomen/Pelvis  <input type="checkbox"/> Abdomen only <input type="checkbox"/> Pelvis only  <input type="checkbox"/> CT Renal Stone w/KUB  <input type="checkbox"/> CT-IVP/Urogram  <input type="checkbox"/> CT Enterography  <input type="checkbox"/> CT Colonography  <input type="checkbox"/> Coronary Artery Calcium</p> <p><b>Spine</b></p> <p><input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic  <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum</p> <p><b>CT Angiogram (CTA)</b></p> <p><input type="checkbox"/> Abdominal Aorta &amp; Iliacs  <input type="checkbox"/> Abdominal Aorta with Runoff  <input type="checkbox"/> Brain  <input type="checkbox"/> Carotids  <input type="checkbox"/> Pulmonary Arteries  <input type="checkbox"/> Renal Arteries  <input type="checkbox"/> Thoracoabdominal Aorta</p>	<p><b>Digital Ultrasound</b></p> <p><b>Abdomen</b></p> <p><input type="checkbox"/> Abdomen  <input type="checkbox"/> Aorta &amp; Retroperitoneum  <input type="checkbox"/> Kidneys &amp; Bladder  <input type="checkbox"/> Limited (AAA, Gall Bladder, Hernia, Lump)</p> <p><b>Vascular</b></p> <p><input type="checkbox"/> Arterial Doppler  <input type="checkbox"/> Upper Extremity  <input type="checkbox"/> Lower Extremity  <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilateral  <input type="checkbox"/> ABI  <input type="checkbox"/> Carotid  <input type="checkbox"/> Renal Artery Doppler  <input type="checkbox"/> with Renals  <input type="checkbox"/> Venous Duplex  <input type="checkbox"/> Upper Extremity  <input type="checkbox"/> Lower Extremity  <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilateral</p> <p><b>GYN</b></p> <p><input type="checkbox"/> Pelvic (with Endovaginal U/S as needed to visualize anatomy)  <input type="checkbox"/> Pelvic Endovaginal (no full Bladder)</p> <p><b>OB</b></p> <p><input type="checkbox"/> Complete (with Endovaginal U/S as needed to visualize anatomy)  <input type="checkbox"/> Limited</p> <p><b>Other</b></p> <p><input type="checkbox"/> Infant Hips <input type="checkbox"/> Scrotum / Testicle  <input type="checkbox"/> Thyroid as needed w/FNA including Afirma Analysis  <input type="checkbox"/> Bladder <input type="checkbox"/> Full <input type="checkbox"/> Postvoid</p>	<p><b>Digital X-Ray</b></p> <p><input type="checkbox"/> Acute Abd Series  <input type="checkbox"/> Chest <input type="checkbox"/> Chest with Ribs  <input type="checkbox"/> Extremity/Joint  <input type="checkbox"/> Spine</p> <p><b>Fluoroscopy</b></p> <p><input type="checkbox"/> Arthrogram  <input type="checkbox"/> Upper GI Series  <input type="checkbox"/> UGI Plus Esophagram  <input type="checkbox"/> Esophagram  <input type="checkbox"/> Barium Enema  <input type="checkbox"/> Single Contrast  <input type="checkbox"/> Air Contrast  <input type="checkbox"/> Dynamic Pharyngeal Evaluation  <input type="checkbox"/> IVP  <input type="checkbox"/> Small Bowel Series  <input type="checkbox"/> VCUG  <input type="checkbox"/> Hysterosalpingogram</p> <p><b>Bone Densitometry (DXA)</b></p> <p><input type="checkbox"/> Bone Mineral Density</p> <p><b>Nuclear Medicine</b></p> <p>Bone Scan  <input type="checkbox"/> Limited  <input type="checkbox"/> Whole Body  <input type="checkbox"/> 3 Phase <input type="checkbox"/> SPECT  <input type="checkbox"/> Gastric Emptying  <input type="checkbox"/> Hepatobiliary (HIDA) w/EF  <input type="checkbox"/> Lung Ventilation/Perfusion  <input type="checkbox"/> Renal Flow &amp; Function  <input type="checkbox"/> Thyroid Uptake &amp; Scan  <input type="checkbox"/> Parathyroid  <input type="checkbox"/> MUGA</p>
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# Patient Instructions and Information

## Type of Examination:

### 3D Mammography, Low Radiation

- Wear a comfortable two-piece outfit.
- Please do not use deodorant or powders before your exam.

### All Breast Biopsies

- Wear comfortable loose clothing.
- Please do not take aspirin or blood thinners 7 days prior to your appointment.
- Please advise our office of any medications you are taking.

### Ultrasound for Abdomen

(Gallbladder, Kidneys, Aorta)

- It is very important that you eat a fat-free meal the evening before your examination.
- Do not eat or drink at least 12 hours before your ultrasound examination.

### Ultrasound for Pelvis and Pregnancy

- Drink 4 large glasses (8 oz.) of non-carbonated fluids (no milk) 1 to 2 hours before the exam. You must have a full bladder for a pelvic ultrasound.

### CT Abdomen/Pelvis

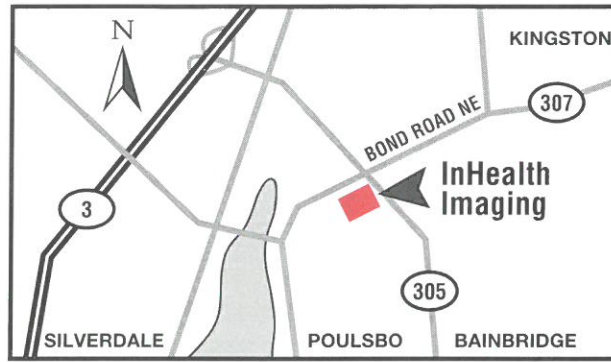
- Nothing by mouth 4 hours before the exam, except your medications and sips of water. Your doctor may instruct you to take oral contrast 1 and 2 hours before the exam.

### DXA

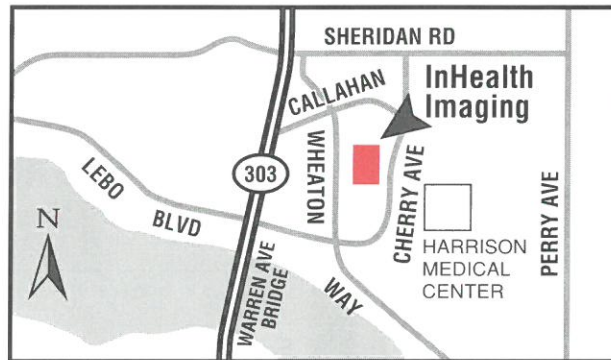
- Comfortable clothing without metal, no calcium supplements, TUMS, etc., 24 hours prior to exam.

### 3T MRI

- Inform us if you have a pacemaker, stents, aneurysm clip, neurotransmitter, any metal objects in your body or eyes, or if you have worked with metal. Wear comfortable clothing.



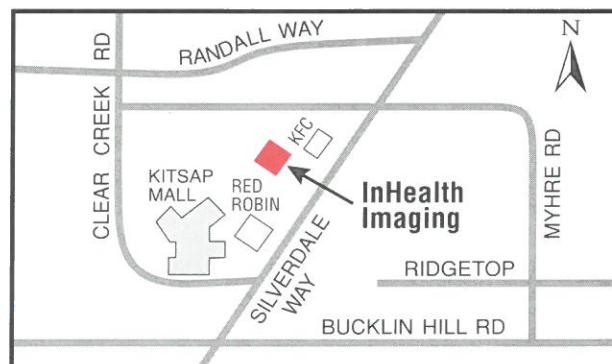
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