* * * Communication Result Report (Oct. 13. 2020 11:23AM) * * *

1) Longevity Medical Clinic
2)

Date/Time: Oct. 13. 2020 11:23AM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
2005	Memory TX	BMI	P. 1	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IP-Fax

Bellevue Medical Imaging, PLLC
1400 116th Ave NE Bellevue, WA. 98004
Phone 425-454-1700 Fax 425-454-0600

Office Hours: M-F 7am-7pm
www.bmirad.com
See exam preparations, map and directions on back

Patient Name: James Jackson DOB: 12/19/1966 Phone #: 206-859-3222
Ins. Provider: _____ Ins. Member #: _____ Precert/Auth #: _____
Referring Physician: Dr. Sabrina Dennet Phone #: 425-576-9272 Fax #: 425-576-0899
Physician Signature: _____ Date: 10/13/2020

[X] BMI to call patient to schedule [ ] Patient will call to schedule [ ] Send CD W/ Pt. [ ] Send CD to Office
[ ] Routine [ ] Stat [ ] Stat Call Report # (_____) [ ] Stat Fax Report

Contrast Allergies [ ] Yes [X] No Pregnant [ ] Yes [X] No Breast Feeding [ ] Yes [X] No

Clinical Signs or Symptoms (REQUIRED): _____

PRIOR RELEVANT IMAGING STUDIES:
Study: _____ Facility: _____ Exam Date: _____

MRI [ ] W/O Contrast [ ] W/ Contrast [ ] Contrast (Per Radiologist Discretion) [ ] Angio [ ] Arthrogram
[ ] Brain [ ] Abdomen [ ] Spine
[ ] Extremity [ ] Pelvis [ ] Breast
[ ] Other

CT [ ] W/O Contrast [ ] W/ Contrast [ ] Contrast (Per Radiologist Discretion) [ ] Angio
[ ] Brain [ ] Chest [ ] Spine
[ ] Abd/Pelvis [ ] Sinus [X] Cardiac Score
[ ] Soft Tissue Neck [ ] Other

Ultrasound [ ] Breast [X] Head/Neck Carotid Doppler
[ ] Abdomen Complete (Liver, Gallbladder, Pancreas, Spleen, Kidney) [ ] Abdomen Limited (Hernia, Groin/Inguinal pain, Appendicitis) [ ] Pelvic (female) (Uterus/Ovaries, Irregular Bleeding, Pelvic Pain)
[ ] Retroperitoneal (Kidneys, Bladder, Prostate) [ ] Extremity [ ] OB LMP_____ DUE DATE_____
[ ] Other

Mammography
[ ] Screening W/ Ultrasound if indicated or requested by patient. [ ] Diagnostic W/ Ultrasound (if patient has symptoms diagnostic exam is required)
[ ] Screening Mammogram Only **Pt will be recalled if further imaging is recommended

X-Ray
[ ] Spine
[ ] Chest
[ ] Other
Right Left Bilateral

Fluoro
[ ] UGI
[ ] Esophagram/Ba Swallow
[ ] Other

DEXA
[ ] DEXA

OTHER EXAM

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Patient Name: James Jackson **DOB:** 12/19/1966 **Phone #:** 206-859-3222
Ins. Provider: _____ **Ins. Member #:** _____ **Precert/Auth #:** _____
Referring Physician: Dr. Samira Ommat **Phone #:** 425-576-9272 **Fax #:** 425-576-0894
Physician Signature: _____ **Date:** 10/13/2020

☒ **BMI to call patient to schedule** ☐ **Patient will call to schedule** ☐ **Send CD W/ Pt.** ☐ **Send CD to Office**
☐ **Routine** ☐ **Stat** ☐ **Stat Call Report #** (_____)_____ ☐ **Stat Fax Report**

Contrast Allergies ☐ **Yes** ☒ **No** **Pregnant** ☐ **Yes** ☒ **No** **Breast Feeding** ☐ **Yes** ☒ **No**

Clinical Signs or Symptoms (REQUIRED): _____

PRIOR RELEVANT IMAGING STUDIES:
Study: _____ Facility: _____ Exam Date: _____

MRI ☐ **W/O Contrast** ☐ **W/ Contrast** ☐ **Contrast** (Per Radiologist Discretion) ☐ **Angio** ☐ **Arthrogram**
☐ Brain_____ ☐ Abdomen_____ ☐ Spine_____
☐ Extremity_____ ☐ Pelvis_____ ☐ Breast_____
☐ Other_____

CT ☐ **W/O Contrast** ☐ **W/ Contrast** ☐ **Contrast** (Per Radiologist Discretion) ☐ **Angio**
☐ Brain_____ ☐ Chest_____ ☐ Spine_____
☐ Abd/Pelvis_____ ☐ Sinus_____ ☒ Cardiac Score_____
☐ Soft Tissue Neck_____ ☐ Other_____

Ultrasound ☐ Breast_____ ☒ Head/Neck Carotid Top plus
☐ Abdomen Complete_____ (Liver, Gallbladder, Pancreas, Spleen, Kidney)
☐ Abdomen Limited_____ (Hernia, Groin/Inguinal pain, Appendicitis)
☐ Pelvic (female)_____ (Uterus/Ovaries, Irregular Bleeding, Pelvic Pain)
☐ Retroperitoneal_____ (Kidneys, Bladder, Prostate)
☐ Extremity_____
☐ OB_____ LMP_____ DUE DATE_____
☐ Other_____

Mammography
☐ Screening W/ Ultrasound if indicated or requested by patient.
☐ Screening Mammogram Only_____
****Pt will be recalled if further imaging is recommended**
☐ Diagnostic W/ Ultrasound_____
(If patient has symptoms diagnostic exam is required)

X-Ray
☐ Spine_____
☐ Chest_____
☐ Other_____
Right Left Bilateral

Fluoro
☐ UGI_____
☐ Esophagram/Ba Swallow_____
☐ Other_____

DEXA
☐ DEXA_____

OTHER EXAM_____