

EASTSIDE CLINIC

615 Lilly Road NE, Suite 100
Olympia, WA 98506
(360) 491-4211
Fax: (360) 493-0407

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R. Trent McKay, M.D.
William W. Peterson, M.D.
Dennis E. Smith, M.D.
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WESTSIDE CLINIC

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(360) 786-8990
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Zachary I. Abbott, D.O.
Clyde T. Carpenter, M.D.
Patrick J. Halpin, M.D.
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TUMWATER CLINIC

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Thomas S. Helpenstell, M.D.
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OLYMPIA
SURGERY CENTER

1625 Mottman Rd. SW, Suite B
Tumwater, WA 98512
(360) 528-8567
Fax: (360) 528-8562

OLYMPIA ORTHOPAEDIC
ASSOCIATES, P.L.L.C.
BUSINESS SERVICES

P.O. Box 368
Olympia, WA 98507
1800 Cooper Pt. Rd. SW-Bldg. 21
Olympia, WA 98502
(360) 455-5144
Fax: (360) 491-7536

BILLING OFFICE
(360) 491-8439
Fax: (360) 491-6328

1-800-936-3386
www.olyortho.com

Dear Dr.

The Olympia Orthopaedics Associates MRI Department is pleased to announce the availability of direct referrals for our services, and we would like to offer you the ability to directly refer patients to our facility for MRI studies. Under current law, we can absorb 25% of our total MRI volume through direct referrals without having to be seen by one of our Orthopaedic Surgeons.

Our MRI center is conveniently located in our Westside Office located at 404 Yauger Way S.W, Suite 100, Olympia, WA.

We take great pride in the services and care that we provide to patients and are proud to announce that we are an ACR Accredited Facility. Our Specialties are Musculoskeletal and Spine Imaging. We have a Siemens Open Scanner, which provides quality images for all patients including claustrophobic patients, and a G.E. 1.5 T High field scanner. Our staff is very qualified and skillful at making sure all of your patient's needs are taken care of while here at our facility.

The process for a direct referral for MRI services is as follows:

- MRI order form completed with Diagnosis code and Dr signature
- All orders pre-authorized before they are faxed to the MRI Dept
- Please be clear on order to the specifics of body parts and rule outs
- If your patient has any anxiety related issues, or may be claustrophobic, please prescribe a pre-exam medication prior to their MRI and document such on the MRI order form.
- Please attach patient demographics and copy of insurance cards

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- Please list patient phone numbers so patient can be screened and scheduled
- Please note on order any special needs of patients
- Fax the completed MRI order form with a copy of the insurance authorization form showing the approval #, date span, and print out if No Auth required to Olympia Orthopaedics MRI Imaging 360-357-6403
- Scan will be read by South Sound Radiology within 24 hours
- Final report will be mailed to your office within 5 business days

I have attached our standard MRI order form, a list of exams and contrast information for you to review.

If you have any questions please feel free to call us at 357-5878. We will do our best to make this appointment a positive experience for your patients, and look forward to serving you.

Sincerely,



Teresa Bowers RT (R)(M)(MR)
MRI Manager

MRI (360) 357-5878 / FAX (360) 357-5878

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**GUIDELINES FOR ORDERING CONTRAST EXAMS OR ARTHROGRAMS
NEEDS GAD:**

BRAIN FOR MS

FIRST TIME SCAN OF SYRINX

ALL METS EXCEPT BONE METS

ANY ABCESS OR INFECTION, ANYWHERE IN THE BODY

POST-OP SPINE (UP TO 2 YRS) POST FUSION FOR SCAR TISSUE

SOFT TISSUE TUMOR / MASS

HIP FOR LABRAL TEARS / ARTHROGRAM

**SHOULDER FOR PAIN , WEAKNESS AND DECREASED ROM /
ARTHROGRAM**

SHOULDER FOR LABRAL TEARS/ARTHROGRAM

**WRIST FOR TFCC TEAR, SYNOVITIS, ULNAR IMPINGEMENT
SYNDROME/ARTHROGRAM**

LIGAMENT TEAR- ARTHROGRAM

DOES NOT NEED GAD:

VERTEBROPLASTY

FRACTURES

BONE METS

MUSCLE TEARS

If the exam is anything other than a routine study please feel free to call us. Together we can determine the best way possible to image what you want to see. Our goal is to achieve the best scan for you and your patient.

Thank You,

Teresa Bowers RT (R)(M)(MR) / MRI Manager / 360-357-5878

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OLYMPIA ORTHOPAEDIC MRI EXAMS

SPINE

CERVICAL
THORACIC
LUMBAR

MUSCULOSKELETAL

FOREFOOT
HINDFOOT
ANKLE
KNEE
HIP
PELVIS
SACRUM
SHOULDER
BRACHIAL PLEXUS
ELBOW
WRIST
HAND
FINGERS

ARTHROGRAMS

WRIST
SHOULDER
HIP

NEUROVASCULAR

MRI / BRAIN	W	W/O
MRA/CAROTID	W	W/O
(NECK)		
MRI / MRA		
(COW)		

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**IMPORTANT DRUG WARNING FOR GADOLINIUM- BASED
CONTRAST AGENTS**

MRI Gadolinium / IV contrast studies can compromise renal function in certain patients. To make certain that your patients are receiving the nationally recognized "Standard of Care", have a safe examination, and are able to tolerate IV Contrast, we have expanded our screening for BUN and Creatinine blood levels for a BMP (Basic Metabolic Panel w/GFR) on MRI Contrast (gadolinium) studies on patients who meet the criteria below.

Criteria for obtaining Creatinine and Bun results

Patients over 60 years of age
Patients with Diabetes
Any renal disease or problems
Significant cardiovascular disease (prior MI, history of CHF)
History of chemotherapy with potentially nephrotoxic agents (e.g., 5 Azacytadine, Carboplatin, Cisplatin, Cyclosporine, Diaziquone, Ifosfamide, IL-2, Methotrexate, Mithramycin, Mitomycin C, Nitrosureas and Streptozocin)

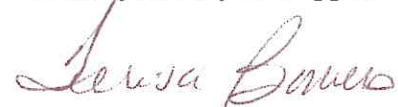
**** Patients with a GFR of <60 ml/min for Gadolinium may be rescheduled to a hospital environment, or may be done as a Non-Contrast study ****

****Lab results with in the last 3 weeks are usually sufficient****

We apologize for any inconvenience this process may cause. The MRI Staff takes great pride in providing the best quality exams, and patient care for our patients here at Olympia Orthopaedics. We feel this nationally recognized "Standard of Care" is an important safeguard for the Patients and for Olympia Orthopaedics.

YOUR PATIENTS SAFETY IS OUR GREATEST CONCERN

Thank you for your support.



Teresa Bowers RT (R) (M) (MR)
MRI Manager
360-357-5878

OLYMPIA ORTHOPAEDIC ASSOCIATES, P.L.L.C.

MAGNETIC RESONANCE IMAGING

404 YAUGER WAY S.W., SUITE 100 OLYMPIA, WA. 98502

PHONE: 360-357-5878 FAX: 360-357-6403

DATE REQUESTED: ___/___/___ PATIENT ACCT#: _____ DOB ___/___/___

PATIENT WEIGHT: _____ PATIENT GENDER: M OR F

PT NAME: _____

PCP:

FAX:

DIAGNOSIS

CODE: _____ R/O: _____

CLINICAL HISTORY/EXAM INDICATION: _____

PRE MRI

X-RAY/LABS

ARTHROGRAM

SKULL 2V

ORBITS

BMP (BASIC METABOLIC PANEL W/ GFR)

EXAM: SIDE: REMARKS

ANKLE R OR L _____

FOOT R OR L _____

KNEE R OR L _____

HAND R OR L _____

WRIST R OR L _____

ELBOW R OR L _____

SHOULDER R OR L _____

BRACHIAL PLEXUS R OR L _____

HIP R OR L _____

C-SPINE _____

T-SPINE _____

L-SPINE _____

NEUROVASCULAR

EXAM SELECT

MRI/ BRAIN W W/O

**MRI/ MRA
(COW)**

**MRA/CAROTID W W/O
(NECK)**

REQUESTED AND SIGNED BY DR.: _____

SCAN DATE: ___/___/___ FOLLOW UP DATE: ___/___/___ TIME: _____ OOA FORM 11-201, REV 03/01/11