SPECIAL INSTRUCTIONS
if your examination is to be one of the following:

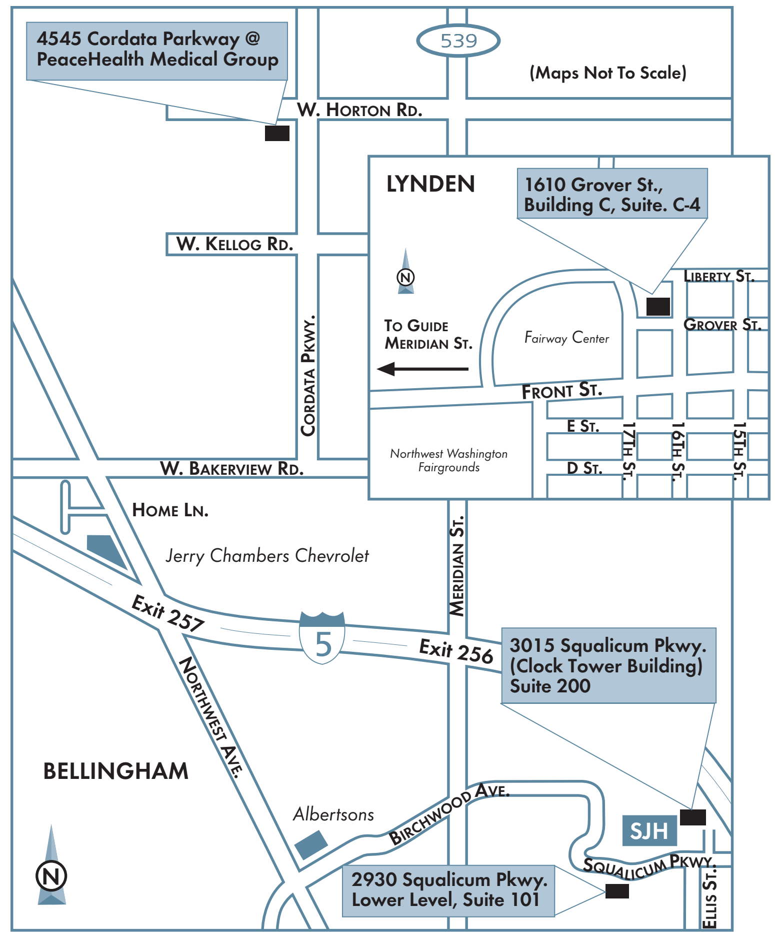
☐ **UPPER GASTRO-INTESTINAL EXAMINATION (Stomach, Esophagus):**
1. Nothing to eat or drink by mouth **(including water)** after 10:00 p.m. the night before examination.
2. Bring morning medications to be taken after exam.

☐ **ESOPHAGUS**
1. Nothing to eat or drink by mouth **(including water)** after 10:00 p.m. the night before examination.
2. Bring morning medications to be taken after exam.

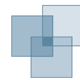
☐ **SMALL BOWEL**
1. On the day before your exam have a clear liquid diet only. This includes clear broth, clear Jell-O, Popsicle's, carbonated beverages, clear juices, water, clear tea or coffee (no milk).
2. Take two (2) Dulcolax tablets between 10 AM and 12 Noon the day before the exam.
3. Take two (2) Dulcolax tablets between 3 PM and 5 PM the day before the exam.
4. Take nothing by mouth the day of the exam until exam is completed.
5. Allow up to 4 hours for this examination.
6. Bring morning medications to be taken after exam.

☐ **BARIUM ENEMA / AIR CONTRAST COLON (Examination of Colon):**
1. Obtain a bowel evacuation kit at least 48 hours before your exam is scheduled. For Bellingham area patients, this kit may be picked up at our Imaging Center office. Patients from areas outside of Bellingham should check with their physician for availability of this bowel evacuation kit.
2. Follow directions enclosed with the bowel evacuation kit.

PLEASE BRING THIS SLIP WITH YOU



X-ray/Fluoroscopy



MT BAKER IMAGING

FLUOROSCOPY FORM & PREPS ON BACK

PLEASE PRESENT THIS SLIP (X-rays performed on a walk-in basis – no appointment needed)

Appointment Time: __________ ☐ A.M. ☐ P.M. Date: __________________________

Patient Name (please print) Last: ______________________________ First: ______________________________ DOB: ______

Examination Requested: ____

Clinical Indications: (Required: must have a sign, symptom or known diagnosis. No "Rule Out" or "Follow-Up"):

____

☐ Previous Films? Yes ☐ No ☐ Location? __________
☐ Patient to return with CD?

Stat Report Desired (choose one)
☐ Fax Report (Fax number required) ______________________
☐ Call Report (Provider cell phone number required) ______________

THIS SPACE IS FOR MT. BAKER IMAGING USE ONLY

Last MP: ______________

Pregnancy: (Yes ☐ No ☐) By: __________

Referring Provider: ______________________________
(print name)

CC: ______________________________
(print name)

X ______________________________
Provider Signature Required

OFFICE USE ONLY – ☐ B/B Marking Area of Concern

Four Locations To Serve You ➔

BELLINGHAM • 2930 Squalicum Parkway, Lower Level, Suite 101 **(X-ray, Fluoro) - FAX #:** 360-733-6596
3015 Squalicum Parkway (Clock Tower Building), Suite 200 **(X-ray) - FAX #:** 360-734-2997
4545 Cordata Parkway @ PeaceHealth Medical Group **(X-ray) - FAX #:** 360-733-9041

LYNDEN • 1610 Grover Street, Suite C-4 **(X-ray) - FAX #:** 360-354-8086

Scheduling: (360) 647-2422 or 1 (800) 767-0430 • **Non-scheduling calls:** (360) 733-0430