**Physician Order Form – Imaging Services**

**PATIENT INFORMATION**

Patient Name: ________________________  Date of Birth: _______________________

Patient Phone: _________________________  ☐ Please call Patient  ☐ Patient will call to schedule

ICD 9 Code: __________________________  Authorization #: ______________________

Reason for Exam: ____________________________________________________________

**REQUESTING PHYSICIAN INFORMATION**

Referring Physician: _________________________  Phone: ________________________

Referring Physician Signature: _______________________

Results (check all that apply):

☐ E-mail report: (e-mail) _________________________  ☐ CD with Images

☐ Fax report: (fax #) _________________________  ☐ Special Request:

☐ Phone Report: (phone #) _________________________

**EXAM FOCUS**

- **MRI**
  - w/ contrast
  - wo/ contrast
  - w/wo contrast

- **CT**
  - w/ contrast
  - wo/ contrast
  - w/wo contrast

- **Mammogram**
  - Diagnostic
  - Screening
  - Others (specify):

- **Ultrasound**
  - Abdomen
  - Pelvis
  - OB/GYN
  - Other (specify):

- **Nuclear Medicine**
  - Bone
  - SPECT
  - Thyroid
  - Liver – Spleen

- **PET/CT**
  - Head/Neck
  - Lung
  - Breast
  - Lymphoma
  - Other (specify):

- **General Radiology**
  - Barium Enema (please select):
    - With air contrast
    - Without air contrast
  - I.V. Pyelogram
  - Upper G.I. (please select):
    - With small bowel series
    - Without small bowel series
  - Voiding Cystourethrogram
  - X-ray (specific):
  - Fluoro Other (specific):

- **Vascular Lab**
  - Upper Extremity
  - Lower Extremity
  - Abdomen (please select):
    - Renal
    - Mesenteric
    - Portal Hepatic
    - AAA
    - Other (specify):
  - Right
  - Left

- **Other**
  - Specify: __________________________

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Form also available at [www.oahshealth.com/provider](http://www.oahshealth.com/provider)
### PATIENT PREPARATION (Please follow carefully)

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Exams with Oral Contrast</td>
<td>Nothing to eat or drink 2 hours prior to exam.</td>
</tr>
<tr>
<td>Barium Enema/Air Contrast</td>
<td>Please call 503-418-0990 for instructions.</td>
</tr>
<tr>
<td>CT</td>
<td>If you are allergic to iodine or CT contrast or think you might be pregnant, please call 503-418-0990.</td>
</tr>
<tr>
<td>I.V. Pyelogram (Kidney X-ray)</td>
<td>Please call 503-418-0990 for instructions.</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Do not wear powder, deodorant, or lotion.</td>
</tr>
<tr>
<td>MRI</td>
<td>If you have had difficulty completing a prior MRI exam, please call 503-418-0990.</td>
</tr>
<tr>
<td>Nuclear Medicine Scan</td>
<td>Bone Scan or Cardiac Stress Test: instructions will be mailed to you. Other Tests: Call 503-494-8468 for instructions.</td>
</tr>
<tr>
<td>PET/CT</td>
<td>Diet and activity restrictions apply. If you are allergic to iodine, please call 503-418-0990.</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Abdomen: Nothing to eat or drink after 12 midnight the evening prior to the exam.</td>
</tr>
<tr>
<td></td>
<td>OB/GYN:</td>
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<tr>
<td></td>
<td>• Drink 32 ounces of water one hour prior to the exam.</td>
</tr>
<tr>
<td></td>
<td>• Do not use the restroom until the exam is completed.</td>
</tr>
<tr>
<td>Upper G.I. – Small Bowel Series</td>
<td>Nothing to eat or drink after 12 midnight the evening prior to the exam. Refrain from chewing gum or smoking until the exam is complete.</td>
</tr>
<tr>
<td>Vascular Lab</td>
<td>Abdomen: Nothing to eat or drink after 12:00 midnight the evening prior to the exam.</td>
</tr>
<tr>
<td>Voiding Cystourethrogram (Bladder Study)</td>
<td>No preparation is necessary. If you are allergic to iodine or CT contrast or if you have any questions, please call 503-418-0990.</td>
</tr>
</tbody>
</table>

**PLEASE REMIND THE PATIENT** of the following:

- Please bring their insurance card to their imaging appointment. Please also remind them to bring a list of their current medications including the dose of the medication and how often they are taking the medication.
- Some contrast exams require a BUN/Creatinine prior to exam.
- If there are any questions about the exam they will be having, please call 503-418-0990.

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**Thank you for choosing OHSU Diagnostic Imaging Services.**

*Our goal is to provide your Patients with Excellent Care. If there is something we can do to accommodate their special needs, please let us know.*

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Diagnostic Imaging Services  
3181 S.W. Sam Jackson Park Road, Portland OR 97239  
Scheduling: 503-418-0990  Fax: 503-494-4621  
Customer Service Manager: 503-418-4969

Form also available at [www.ohsuhealth.com/provider](http://www.ohsuhealth.com/provider)