Physician Order Form – Imaging Services

Diagnostic Imaging Services
3181 S.W. Sam Jackson Park Road, Portland, OR 97239
Phone: 503-418-0990 Fax: 503-494-4621

Date: ____/____/____

PATIENT INFORMATION

Patient Name (**REQUIRED**): _____ Date of Birth (**REQUIRED**): _____

Patient Phone:_____ ❑ **Please call 503-418-0990** to schedule*

❑***Nuc Med/PET*** call 503-494-8468 to schedule, fax order to 503-494-2879 ❑***Breast Imaging*** call 503-494-4673, fax order to 503-418-8980

*****PLEASE CONTACT OHSU at 503-494-8311 for ECHO/EKG and DEXA Scans. These exams are not done through Diagnostic Imaging*****

ICD 9 Code (**REQUIRED**):_____ Authorization #: _____

Reason for Exam (**REQUIRED**):_____

REQUESTING PHYSICIAN INFORMATION

Referring Physician (**REQUIRED**): _____ Phone (**REQUIRED**): _____

Referring Physician Signature (**REQUIRED**): _____

Results (check all that apply):
❑ E-mail report: (e-mail) _____ ❑ CD with Images
❑ Fax report: (fax #) _____ ❑ Special Request: _____

EXAM	FOCUS
❑ **MRI** ❑ w/ contrast ❑ wo/ contrast ❑ w/wo contrast	❑ Brain MRI ❑ Brain MRA ❑ Neck MRI ❑ Neck MRA ❑ Cervical Spine ❑ Thoracic ❑ Lumbar ❑ Extremity (specify): _____ ❑ Other (specify): _____ ❑ Vagal Nerve Stimulator: Program both generator output current and magnet output current to OMA prior to the MRI procedure. After MRI is completed, re-program device to original settings.
❑ **CT** ❑ w/ contrast ❑ wo/ contrast ❑ w/wo contrast	❑ Brain ❑ Sinus ❑ Chest ❑ Abdomen ❑ Pelvis ❑ Cervical Spine ❑ Thoracic ❑ Lumbar ❑ Other (specify):_____ ❑ Extremity (specify): _____ ❑ Coronary Artery Calcium Score ❑ Coronary CTA with Calcium Scoring ❑ Lung Cancer Screening (**Questions on reverse MUST be answered for this order**)
❑ **Mammogram** Call: 503-494-4673 Fax: 503-418-8980	❑ Diagnostic ❑ Screening ❑ Other (specify):
❑ **Ultrasound**	❑ Abdomen ❑ Pelvis ❑ OB/GYN ❑ Other (specify):
❑ **Nuclear Medicine** Call: 503-494-8468 Fax: 503-494-2879	❑ Bone ❑ Brain ❑ Cardiac ❑Gastric ❑ Liver ❑ Lung ❑ Lymph ❑ Renal ❑ Thyroid ❑Tumor ❑ Other (specify):
❑ **PET/CT**	❑ Bone ❑ Brain ❑ Cardiac ❑ Eyes to Thighs ❑ Whole Body ❑ Other (specify):
❑ **General Radiology**	❑ Barium Enema (please select): ○ With air contrast ○ Without air contrast ❑ Esophagram ❑ Upper G.I. (please select): ○ With small bowel series ○ Without small bowel series ❑ Voiding Cystourethrogram ❑ X-ray (specify views and laterality): _____ ❑ Fluoro Other (specify):
❑ **Vascular Lab** ❑ Upper Extremity ❑ Lower Extremity ❑ Finger ❑ Toe(s) ❑ Right ❑ Left	❑ Peripheral Arial Exam ❑ Venous ❑ Chronic Venous Exam ❑ PPG's ❑ Transcranial Doppler ❑ Carotid ❑ Temporal Artery ❑ ABI's with waveform ❑ Nielsen Cold Challenge ❑ Graft Flow ❑ Arterial Duplex ❑ Dialysis Graft Eval. ❑ Abdomen (please select): ○ Renal ○ Mesenteric ○ Portal Hepatic ○ AAA ○ Renal Transplant ❑ Other (specify):
❑ **Other**	

CT LUNG CANCER SCREENING - IF THE PATIENT IS EXPERIENCING PULMONARY SIGNS OR SYMPTOMS, OR IS OUTSIDE THE AGES OF 55-80 YEARS (55-77 FOR MEDICARE PATIENTS), CONSIDER ORDERING A CT CHEST WO CONTRAST	
REQUIRED QUESTIONS *(Consider ordering a CT Chest WO Contrast if any STOP answers are selected)*	• Is the patient between age 55-80 (55-77 for Medicare)? ❑ **YES** (Continue) ❑ **NO** (STOP) • Is the patient experiencing active pulmonary signs or symptoms? ❑ **YES** (STOP) ❑ **NO** (Continue) • Does patient have a history of lung cancer? **YES** (STOP) ❑ **NO** (Continue) • Does the patient have a smoking history of more than 30 pack years? ❑ **YES** (Continue) ❑ **NO** (STOP) • If patient has stopped smoking, the patient has stopped within the last 15 years: ❑ **YES** (Continue) ❑ **NO** (STOP) **MEDICARE PATIENTS ONLY:** • Has the patient had a shared decision making visit: ❑ **YES** (Continue) ❑ **NO** (STOP) • Has the patient had smoking cessation counseling: ❑ **YES** (Continue) ❑ **NO** (STOP)

PATIENT PREPARATION (Please follow carefully)	
All Exams with Oral or IV Contrast	Nothing to eat or drink 2 hours prior to exam.
Barium Enema/Air Contrast	Please call 503-418-0990 for instructions.
CT	If you are allergic to CT contrast or think you might be pregnant, please call 503-418-0990.
Mammogram	Do not wear powder, deodorant or lotion. For further instructions or to schedule call 503-494-4673.
MRI	**If you think you may be pregnant, please contact your physician prior to your MRI.** If you have had difficulty completing a prior MRI exam, are allergic to MRI contrast, **or have any kind of implants or implanted devices** (pacemakers, shunts, pumps, etc.), please call 503-418-0990. **All piercings must be removed prior to your MRI.**
Nuclear Medicine Scan	Bone Scan or Cardiac Stress Test: instructions will be mailed to you. Other Tests: Call 503-494-8468 for instructions.
PET/CT	Diet and activity restrictions apply. If you are allergic to iodine, please call 503-418-0990.
Ultrasound - Abdomen	**Abdomen:** Nothing to eat or drink after 8 hours prior to the exam. **OB:** Please do not use the restroom for one hour prior to the exam.
Upper G.I. – Small Bowel Series	Nothing to eat or drink after 8 hours prior to the exam.
Vascular Lab	Abdomen: Nothing to eat or drink after 8 hours prior to the exam.
Voiding Cystourethrogram (Bladder Study)	No preparation is necessary. If you are allergic to iodine or CT contrast or if you have any questions, please call 503-418-0990.

PLEASE REMIND THE PATIENT of the following:

- Please bring their insurance card to their imaging appointment.
- Some CT and MRI exams require a Creatinine prior to exam.
- If there are any questions about the exam they will be having, please call 503-418-0990.
- If you are prescribing pain or anxiety medication for your patient, please instruct them to bring an adult to drive them home or accompany them on public transportation.

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.

Diagnostic Imaging Services
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Scheduling: 503-418-0990 Fax: 503-494-4621
Customer Service Manager: 503-418-4969