OHSU Physician Order Form IMAGING SERVICES

OHSU 3181 S.W. Sam Jackson Park Road Portland, OR 97239-3098 TEL **503-418-0990** FAX **503-494-4621**

Patient information

Patient name: Date of birth:

Phone #: ◯ PLEASE CALL PATIENT ◯ PATIENT WILL CALL TO SCHEDULE

ICD-9 Code: Authorization #:

Reason for exam:

Requesting physician information

Referring physician: Phone #:

Reffering physician signature:

Results (check all that apply):

◯ EMAIL REPORT (Email): ◯ FAX REPORT (Fax #): ◯ PHONE REPORT (Phone #):

◯ CD WITH IMAGES ◯ SPECIAL REQUEST:

Exam	Focus
◯ MRI ◯ W/ CONTRAST ◯ W/OUT CONTRAST	◯ BRAIN MRI ◯ BRAIN MRA ◯ NECK MRI ◯ NECK MRA ◯ CERVICAL SPINE ◯ THORACIC ◯ LUMBAR ◯ EXTREMITY (SPECIFY): ◯ OTHER (SPECIFY): ◯ VAGAL NERVE STIMULATOR: Program both generator output and magnet output current to OMA prior to the MRI procedure. after MRI is completed, reprogram device to original settings.
◯ CT ◯ W/ CONTRAST ◯ W/OUT CONTRAST	◯ BRAIN ◯ SINUS ◯ CHEST ◯ ABDOMEN ◯ PELVIS ◯ CERVICAL SPINE ◯ THORACIC ◯ LUMBAR ◯ EXTREMITY (SPECIFY): ◯ OTHER (SPECIFY):
◯ 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 (SELECT): ◯ W/ AIR CONTRAST ◯ W/OUT AIR CONTRAST ◯ IV PYELOGRAM ◯ UPPER GI (SELECT): ◯ W/ SMALL BOWEL SERIES ◯ W/OUT SMALL BOWEL SERIES ◯ VOIDING CYSTOURETHROGRAM ◯ X-RAY (SPECIFY): ◯ FLUORO OTHER (SPECIFY):
◯ VASCULAR LAB ◯ UPPER EXTREMITY ◯ LOWER EXTREMITY ◯ FINGER ◯ TOE(S) ◯ RIGHT ◯ LEFT	◯ PERIPHERAL ARIAL EXAM ◯ VENOUS ◯ CHRONIC VENOUS EXAM ◯ PPGs ◯ TRANSCRANIAL DOPPLER ◯ CAROTID ◯ TEMPORAL ARTERY ◯ ABIs W/ WAVEFORM ◯ NIELSEN COLD CHALLENGE ◯ GRAFT FLOW ◯ ARTERIAL DUPLEX ◯ DIALYSIS GRAFT EVAL. ◯ ABDOMEN (SELECT): ◯ RENAL ◯ MESENTERIC ◯ PORTAL HEPATIC ◯ AAA ◯ RENAL TRANSPLANT ◯ OTHER (SPECIFY):

◯ OTHER (SPECIFY):

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