Physician Order Form for Imaging Services

Diagnostic Imaging Services 3181 SW Sam Jackson Park Road, Portland OR 97239   
**Radiology Scheduling: 503-418-0990** Fax: 503-494-4621

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **REQUIRED FIELDS: Patient Demographics and Physician Order Information** | | | | | | |
| **Patient Name:** DOB : / / Height: Weight: Phone: | | | | | | |
| **Referring Physician Name: Signature:** | | | | | | |
| 🞏 URGENT 🞏 ROUTINE  **ICD-10 Code(s):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ICD-10 Description:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Decision Support Score: \_\_\_\_\_ Decision Support #: \_\_\_\_\_\_\_\_\_ | | | | | Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorization Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorization Dates: \_\_\_\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected by (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Check all that apply** | | | | | | |
| 🞏 Needs physical assistance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Needs interpreter. Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Coming from Care Facility  Facility contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Facility contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | 🞏 Difficult IV Start  🞏 Port 🞏 PICC 🞏 Other central line:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Patient has a trach 🞏 Patient on a ventilator  🞏 Pregnant - # Weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Pediatric Sedation 🞏 Adult General Anesthesia  Anxiolytics Needed? **Indicate reason for meds/sedation/GA on pg 2.** | | | |
| **MRI** (failure to document implants may delay patient care) | | | | | | |
| **Implants** | 🞏 Pacemaker 🞏 DBS 🞏 Other Implant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Make/Model/Implant Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 VNS (Vagus Nerve Stimulator) - Program Pulse Generator, Magnet, and AutoStim output currents (if applicable), to OmA prior to MRI.  After MRI is completed, reprogram device to original settings. | | | | | |
| 🞏 Without Contrast 🞏 With and Without Contrast 🞏 Gadolinium allergy 🞏 On Dialysis | | | | | | |
| 🞏 Pelvis 🞏 Abdomen 🞏 Brain  **Spine**: 🞏 Cervical 🞏 Thoracic 🞏 Lumbar  🞏 Cardiac (comprehensive and velocity flow w/wo contrast) | | | | 🞏 Arthrogram (With Fluoro) 🞏 Left 🞏 Right 🞏 Bilateral  Specify Joint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Extremity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Left 🞏 Right 🞏 Bilateral | | |
| 🞏 Other MRI: | | | | | | |
| **CT** | | | | | | |
| 🞏 CT With Contrast 🞏 CT Without Contrast 🞏 CT With & Without Contrast 🞏 CTA (CT Angiogram) 🞏 CT Contrast Allergy | | | | | | |
| 🞏 Brain 🞏 Neck 🞏 Maxillofacial 🞏 Sinus  🞏 Chest 🞏 Abdomen 🞏 Pelvis  **Spine**: 🞏 Cervical 🞏 Thoracic 🞏 Lumbar  **Colonography:** 🞏 Diagnostic 🞏 Screening | | | | 🞏 Weight Bearing CT (WBCT) Extremity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Laterality: 🞏 Left 🞏 Right 🞏 Bilateral | | |
| 🞏 Coronary Artery Calcium Score (without contrast) 🞏 Coronary CTA & Calcium Scoring (with & without contrast) | | |
| 🞏 CT Lung Cancer Screening (Questions on reverse must be filled out and received in addition to order form) | | | | | | |
| 🞏 Other CT: | | | | | | |
| **GENERAL RADIOLOGY** | | | | | | |
| 🞏 Barium Enema 🞏 Barium Enema With Air contrast  🞏 Upper GI 🞏 UGI with Small Bowel Series  🞏 Esophogram m 🞏 Myelogram 🞏 Lumbar Puncture  🞏 Voiding Cystourethrogram 🞏 VCUG with sedation | | | | 🞏 Joint injection (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 X-ray Body part:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Laterality: 🞏 Left 🞏 Right 🞏 Bilateral  Specific Views & #: | | |
| **ULTRASOUND** | | | | | | |
| 🞏 Abdomen 🞏 Pelvis 🞏 Kidney and Bladder 🞏 Thyroid  🞏 Testes 🞏 Head | | | | 🞏 US Pregnant Uterus less than 14 weeks gestation  🞏 OB US 14 weeks, Fetus 🞏 OB Transvaginal | | |
| **Axilla:** 🞏 Left 🞏 Right 🞏 Bilateral | | | | Other US : | | |
| **VASCULAR** | | | | | | |
| 🞏 Upper Extremity 🞏 Lower Extremity 🞏 Right 🞏 Left  🞏 Finger(s) 🞏 Toe(s) | | 🞏 Arterial Duplex 🞏 Carotid Artery  🞏 Venous Duplex 🞏 Vein Mapping  🞏 Venous Reflux study 🞏 Laser Doppler | | | | 🞏 Temporal Artery 🞏 PPG’s 🞏 Graft Flow  🞏 Transcranial Doppler 🞏 Dialysis Graft Eval  🞏 Raynaud’s Cold Challenge 🞏 ABI’s w/ waveform |
| **Abdomen**: 🞏 AAA 🞏 Mesenteric 🞏 Portal Hepatic 🞏 Renal 🞏 Renal Transplant | | | | |

|  |  |  |
| --- | --- | --- |
| CT LUNG CANCER SCREENING – IF THE PATIENT IS EXPERIENCING PULMONARY SIGNS OR SYMPTOMS, OR IS OUTSIDE THE AGES OF 55-80 (55-77 FOR MEDICARE PATIENTS), CONSIDER ORDERING A CT CHEST WO CONTRAST | | |
| **ALL QUESTIONS BELOW ARE REQUIRED FOR SCHEDULING**  Consider ordering a CT Chest WO Contrast if any **STOP** answers are selected. | | |
| Patient is **on** **Medicare** **AND** between the age of **55-77** | OR |  YES (Continue)  NO (STOP) |
| Patient is between the age of **50-80** |  YES (Continue)  NO (STOP) |
| Does patient show any signs or symptoms of lung cancer? | |  YES (STOP)  NO (Continue) |
| Is this the first (baseline) CT or an annual exam? |  First Screening (baseline)  Annual Screening | |
| Patients Current Smoking Status |  Current smoker  Former Smoker  Smoker, status unknown | |
| **If Former Smoker:** Number of years ago pt. quit smoking | # of Years: (STOP if greater than 15 years) | |
| Total Number of Pack Years patient smoked | # of Pack Years: (STOP if less than 20 pack years) | |
| Is there documentation of share decision making? |  YES  NO (required prior to baseline screening) | |
| Did the patient receive cessation guidance? |  YES  NO (required prior to baseline screening) | |

|  |  |
| --- | --- |
| **PATIENT PREPARATION (Please follow carefully)** | |
| Barium Enema/ Air Contrast | Call 503-418-0990 for instructions. |
| CT | Indicate allergy to iodine or contrast on front.  Confirm pregnancy status. |
| MRI | If the patient has had difficulty completing an MRI in the past, has an allergy to contrast, has implants or devices, or is pregnant, please **tell the scheduler** **and indicate on front of form.** |
| Ultrasound | **Abdomen** ultrasounds: must be fasting; nothing to eat or drink for 6-8 hours prior to scan. |
| Upper G.I. – Small Bowel Series | Nothing to eat or drink 8 hours prior to the exam except small sips of water for medication. Confirm patient is not pregnant prior to exam. |
| Vascular Lab | Abdomen: Nothing to eat or drink 8 hours prior to the exam except small sips of water for medication |
| Voiding Cystourethrogram (Bladder Study – VCUG) | No preparation is necessary.  If allergic to iodinated contrast, please indicate on front page and let your scheduler know. Confirm patient is not pregnant prior to exam. |
| General Anesthesia & Pediatric Sedation  **\*There is no moderate sedation for adult MRI** | For Pediatric patients: A pediatric sedation nurse will contact the patient regarding fasting instructions for patient sedation. |
| MRI Anxiolytics for Claustrophobia/ PTSD | Prescribe oral and have patient pick up from local pharmacy.  Patient will need a ride home or someone to accompany them on public transportation (unless using medical transport). |
| MRI table limit is 550lbs  CT table limit is 600lbs | If the patient is over 300lbs, please call Radiology Scheduling for measurement instructions. |

|  |  |
| --- | --- |
| **REMINDERS:** | |
| * Please ask patient to call Radiology scheduling at **503-418-0990** to schedule their imaging. * If patient is new to OHSU or their insurance has changed, please have them call OHSU Registration at 503-494-8505 or 888-222-6478 and provide their insurance information prior to calling to schedule. * **Please confirm the authorization of the requested exam(s) has been obtained by the ordering clinic prior to the appointment.** * If your patient requires oral anxiolytics, please order these to be picked up from their local pharmacy. If oral anxiolytics have failed, required IV anxiolytics must documented on the order form. If IV anxiolytics have failed, required adult or pediatric anesthesia services must be documented on the order. Please indicate reason why patient requires medication to complete the scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Patient must arrange transportation if they will be receiving pain/anxiety/aesthesia medication. Patient must have a responsible adult (16 years or older) who is present at the time they are discharged. Patient may NOT drive. If patent plans to take public/private transportation, they must have a responsible adult with them. * Some CT and MRI exams require a Creatinine (blood test) prior to the exam. * Patients must bring a responsible person with them to supervise children and/or service animals that may be with them during their appointment. | |
| **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. Patients can provide their email address at the time of scheduling or at check-in to provide feedback on their experience.* |