

Physician Order Form for Pediatric Imaging Services



Diagnostic Imaging Services 3181 SW Sam Jackson Park Road, Portland OR 97239

Radiology Scheduling: 503-418-5252

Fax: 503-418-5253

REQUIRED FIELDS: Patient Demographics and Physician Order Information

Patient Name: _____ DOB: / / Height: _____ Weight: _____ Phone: _____

Referring Physician Name: _____ Signature: _____

<input type="checkbox"/> URGENT <input type="checkbox"/> ROUTINE ICD-10 Code(s): _____ ICD-10 Description: _____ Additional Information: _____ _____	Phone #: _____ Fax #: _____ Authorization Number: _____ Authorization Dates: _____ - _____ Expected by (date): _____ <input type="checkbox"/> Mail CD of Images (Complete pg. 2) Results always faxed
--	---

Check all that apply

<input type="checkbox"/> Needs physical assistance: _____ <input type="checkbox"/> Needs interpreter. Language: _____ <input type="checkbox"/> Coming from Care Facility Facility contact name: _____ Facility contact number: _____	<input type="checkbox"/> Difficult IV Start <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Other central line: _____ <input type="checkbox"/> Patient has a trach <input type="checkbox"/> Patient on a ventilator <input type="checkbox"/> Pregnant - # Weeks: _____ <input type="checkbox"/> Pediatric Sedation
--	---

GENERAL RADIOLOGY

<input type="checkbox"/> Barium Enema <input type="checkbox"/> Barium Enema With Air contrast <input type="checkbox"/> Upper GI <input type="checkbox"/> UGI with Small Bowel Series <input type="checkbox"/> Esophogram <input type="checkbox"/> MBS, Tube Replacements <input type="checkbox"/> Voiding Cystourethrogram <input type="checkbox"/> VCUG with sedation	<input type="checkbox"/> X-ray Body part: _____ Laterality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral Specific Views & #: _____
---	---

ULTRASOUND

<input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Kidney and Bladder <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotum <input type="checkbox"/> Head	<input type="checkbox"/> Hip, Spine, Soft Tissue Head and Neck, Breast (Under 14)
Axilla: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	Other US: _____

Clinic Mailing Address (If Physical CD of Images is requested)

Clinic Name: _____
 Street: _____
 State: _____ Zip: _____

Provide FedEx info, if requesting expedited mailing: _____

REMINDERS:

- Please ask patient to call Radiology scheduling at 503-418-5252 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.
- 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 patient plan to take public/private transportation, they must have a responsible adult with them.
- 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.