Physician Order Form for Nuclear Medicine Imaging

FAX completed form to: 503-494-2879 Nuclear Medicine Scheduling Phone: 503-494-8468
*Required information is indicated in **BOLD**, this request will be returned unscheduled if incomplete*

Patient Information

Patient Name: (Last, First) _____ **DOB: / / Height:** _____ **Weight:** _____
OHSU Medical Record Number: _____ **Legal Sex: ☐ M ☐ F Phone:** _____
Insurance Plan: _____ Member Insurance #: _____

Physician and Order Information

Referring Physician Name: **Signature:**

☐ URGENT ☐ ROUTINE
☐ Radiology to call patient to schedule exam
NPI: _____
Office Contact: _____

Phone Number: _____
Fax Number: _____
Authorization Number: _____
Authorization Dates: _____ - _____

ICD-10 Code(s):
Diagnosis:

Prior PET/CT Exam: ☐Yes ☐No
Pregnant: ☐Yes ☐No ☐N/A

Other prior imaging studies: (Check all that apply) ☐ CT ☐ MRI ☐ US ☐ None ☐ Other _____
Diabetic: ☐Yes ☐No Renal Disease: ☐Yes ☐No Claustrophobic: ☐Yes ☐No If Yes, ☐Rx Anxiolytics or ☐Anesthesia
☐Needs physical assistance: _____ ☐Difficult IV Start/Needs IV Therapy ☐CT Contrast/Iodine Allergy
Central Line: ☐Port ☐PICC ☐Other _____ ☐Needs interpreter - Language: _____
Results needed for next appointment? **☐Yes ☐No** If yes, next appointment Date: _____ Time: _____

PET (PET/CT is routinely used for Tumor Imaging of the body. This exam includes a low dose non-contrast CT scan.) **Please indicate an exam below.**

☐ Brain PET
☐ Seizure ☐ Tumor ☐ Dementia ☐ Other: _____
☐ Whole Body PET *Please identify primary cancer:*
_____
☐ Skull Base to Mid-Thigh PET *Please identify primary cancer:*
_____
☐ Head and Neck PET *Please identify primary cancer:*
_____
☐ PSMA PET (Pylarify) for Prostate Ca
☐ Axumin PET for Prostate Ca
☐ DETECTNET (Cu64 Dotatate) for Neuroendocrine Ca
☐ Cardiac PET
☐Sarcoid ☐Viability ☐Other: _____
If Viability, please also order Myocardial Perfusion Rest Only

Indication for PET Tumor Scan:
☐ Initial treatment strategy
☐ Subsequent treatment strategy
Other: _____

Include Diagnostic CT with IV contrast:
☐ Neck CT with IV contrast
☐ Chest CT with IV contrast
☐ Abdomen CT with portal phase IV contrast
☐ Pelvis CT with portal phase IV contrast
☐ Other: _____
Diagnosis/ICD-10 Code(s) for diagnostic CT Scan(s):

Additional clinical history and symptoms:

Physician Signature: _____ **(MD, DO, NP, PA) Date:** _____
Preferred Location: ☐ Portland Main Campus ☐ Beaverton

Additional information and questions below:
Confirm pregnancy status.
CT: Indicate allergy to iodine or contrast on front of order form.
Please indicate height and weight on order form.
PET/CT table limit is 500lbs.

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 Nuclear Medicine scheduling at 503-494-8468 to schedule their imaging.
• Nuclear Medicine can also be reached by email: nucmed@ohsu.edu
• 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.
• Anxiolytics for Claustrophobia/ PTSD: 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/anesthesia 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 plans 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.