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

OHSU

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:_____

_____

Phone #: _____ Fax #: _____

Authorization Number: _____

Authorization Dates: _____- _____

Expected by (date): _____

☐ Mail CD of Images (Complete pg. 2) *Results always faxed*

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 W ☐ Chest WO ☐ Abdomen ☐ Pelvis

Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar

Colonography: ☐ Diagnostic ☐ Screening

☐ Other CT:

☐ Weight Bearing CT (WBCT) Extremity_____

Laterality: ☐ Left ☐ Right ☐ Bilateral

☐ Coronary Artery Calcium Score (without contrast)

☐ Coronary CTA & Calcium Scoring (with & without contrast) & FFR*

☐ CTA Screening for Non-Calcified Coronary Plaque w/contrast

☐ CT Lung Cancer Screening (Questions on reverse must be filled out and received in addition to order form)

GENERAL RADIOLOGY

☐ Barium Enema ☐ Barium Enema With Air contrast

☐ Upper GI ☐ UGI with Small Bowel Series

☐ Esophogram ☐ 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

Axilla: ☐ Left ☐ Right ☐ Bilateral

☐ US Pregnant Uterus less than 14 weeks gestation

☐ OB US 14 weeks, Fetus ☐ OB Transvaginal

Other US :

VASCULAR

☐ Upper Extremity

☐ Lower Extremity

☐ Right ☐ Left

☐ Finger(s) ☐ Toe(s)

☐ Arterial Duplex ☐ Carotid Artery ☐ Temporal Artery ☐ PPG's ☐ Graft Flow

☐ Venous Duplex ☐ Vein Mapping ☐ Transcranial Doppler ☐ Dialysis Graft Eval

☐ Venous Reflux study ☐ Laser Doppler ☐ 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 50-80 (50-77 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 **50-77**	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 ☐ Annual Screening | Prior Location:		
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)	
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, indicate on front of form.
Voiding Cystourethrogram (Bladder Study – VCUG)	If allergic to iodinated contrast, please indicate on front page and let your scheduler know. Confirm patient is not pregnant prior to exam.
MRI Anxiolytics for Claustrophobia/ PTSD	Prescribe oral and have patient pick up from local pharmacy.
If over pt is over 300lbs, please indicate height and weight on order form.	MRI table limit is 550lbs, measurements required on order form. CT table limit is 600lbs, measurements required on order form.

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 **503-418-0990** 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.
- *For all CTA Coronary studies, the radiologist will make a determination at the time of report if Fractional Flow Reserve (FFR) Analysis is required.
- **For all Lumbar Punctures, please include orders for any required labs:_____

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.