



# 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/MRI Exam:**  Yes  No  
**Pregnant:**  Yes  No  N/A

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

**PET/MRI** is typically performed with a dedicated MRI in addition. **Please indicate one or more exams.**

Brain PET/MRI  
     Seizure  Tumor  Dementia  Other: \_\_\_\_\_

Whole Body FDG PET/MRI or  Skull-Base to Mid-Thigh  
*Please identify primary cancer:*  
\_\_\_\_\_

PET/MRI PSMA Pylarify for Prostate Ca  
 Axumin PET/MRI for Prostate Ca  
 NETSPOT PET/MRI (Cu64 Dotatate) for Neuroendocrine Ca  
 Cardiac PET/MRI  
     Sarcoid  Other: \_\_\_\_\_

Indication for PET/MRI Scan:  
 Initial treatment strategy  
 Subsequent treatment strategy  
Other: \_\_\_\_\_

Please indicate dedicated Diagnostic MRI to be performed.

Brain MRI  
 Cardiac MRI  
 Abdomen MRI  
 Pelvis MRI  
 Other: \_\_\_\_\_

\_\_\_\_\_

with IV contrast    without IV contrast  
 with and without IV contrast

*Diagnosis/ICD-10 Code(s) for diagnostic PET/MRI Scan(s):*  
\_\_\_\_\_

Additional clinical history and symptoms:  
\_\_\_\_\_

Please provide information about metal implants  
(Implant/Make/Model): \_\_\_\_\_ Date implanted: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **(MD, DO, NP, PA) Date:** \_\_\_\_\_

**Additional information and questions below:**

**PET/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.

Please indicate height and weight on order form and include measurements below if required.

PET/MRI table limit is 500lbs, measurements required on order form for patients 250lbs or above.

Measurements from elbow to elbow or widest part of body while lying flat on a hard surface: \_\_\_\_\_

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.
- 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: General anesthesia and pediatric sedation are not available for PET/MRI. 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 be documented on the order form. Please indicate reason why patient requires medication to complete the scan: \_\_\_\_\_
- Patient must arrange transportation if they will be taking pain/anxiety 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.
- Some patients may require Orbits X-ray prior to PET/MRI
- 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.*