OHSU Health

DIAGNOSTIC IMAGING SERVICES ORDER FORM

TIN:92 2142300

☐ **OHSU Health Diagnostic Imaging Clinic, Cedar Hills**
9775 S.W. Wilshire St., Suite 100, Portland, OR 97225

☐ **OHSU Health Diagnostic Imaging Clinic, NE Portland**
1800 N.E. Second Ave, Portland, OR 97212

TO REQUEST IMAGING, FAX THIS FORM TO **503-346-8600** TO SCHEDULE, CALL **503-346-4949**

PATIENT DEMOGRAPHICS REQUIRED FIELDS, ALL MUST BE COMPLETE.

Patient Name _____ DOB _____ Height _____ Weight _____
Phone Number _____ Cell Number _____ Other Contact _____

Referring Physician Name _____
Symptoms / Reason for Exam _____

Physician Signature _____

☐ **URGENT** ☐ **ROUTINE**

ICD-10 Codes _____
ICD-10 Description (required)_____
_____
Additional Information _____

Ordering Phone Number_____
Ordering Fax Number _____
☐ Request Access to Online Images
Clinic Contact_____
Clinic Address_____
_____

☐ **OBTAIN PRIOR AUTHORIZATION**

Insurance_____
ID Number_____
Group Number_____
Subscriber Name _____
Authorization Number_____
Authorization Dates_____-_____

☐ **PRIOR AUTHORIZATION INFORMATION**

MVA / WC_____
Claim Rep Name_____
Claim Rep Phone Number_____
Claim Number_____ _____
Date of Injury _____

MRI (FAILURE TO DOCUMENT IMPLANTS MAY DELAY PATIENT CARE)

☐ Pacemaker ☐ DBS ☐ Other Implant _____ Make / Model / Implant Date _____
☐ NS (Nerve Stimulator) _____
☐ Ortho Implant Location _____ Stent / Coil Location _____

☐ **WITHOUT CONTRAST** ☐ **WITH AND WITHOUT CONTRAST** ☐ **GADOLINIUM ALLERGY** ☐ **ON DIALYSIS**

☐ Brain MRI ☐ Brain MRA ☐ Seizure Brain
☐ MRA Carotid ☐ MRV Head ☐ ST Neck
☐ Orbits ☐ Pituitary ☐ IAC
☐ Trigeminal ☐ CSF Flow ☐ Cervical
☐ Thoracic ☐ Lumbar ☐ Sacrum (SI Joints)
☐ Lumbosacral Plexus
☐ Other _____

☐ Knee ☐ Left ☐ Right
☐ Shoulder ☐ Left ☐ Right
☐ Extremity_____ ☐ Left ☐ Right ☐ Bilateral
☐ Abdomen ☐ Female Pelvis ☐ Liver ☐ MRCP
☐ Pelvis Soft Tissue ☐ Pelvis: Bony ☐ Pudendal Nerve
☐ Pelvis Sciatic Nerve ☐ Piriformis ☐ Brachial Plexus
☐ Prostate – ECOIL ☐ Yes ☐ No

☐ **PATIENT REFERRAL MAY BE TRANSFERRED TO ALTERNATE OHSU SITE IF STUDY IS NOT AVAILABLE AT OUTPATIENT IMAGING CENTER**

CHECK ALL THAT APPLY

☐ Requires Physical Assistance*_____
☐ Needs an Interpreter _____
☐ Preferred Language _____
☐ Coming from Care Facility:
Care Facility Contact Name _____
Care Facility Phone Number _____

☐ Difficult IV Start*_____
☐ Port ☐ PICC ☐ Other Central Line _____
☐ Patient has a Trach* ☐ Patient on a Ventilator*
☐ Number of Weeks Pregnant_____

*Patient may need imaging to be completed in a hospital imaging center – determined by screening questions.