Physician Order Form for Imaging Services

OHSU Diagnostic Imaging Services

Radiology Scheduling: 503-418-0990 | Please ask patient to call Radiology scheduling to schedule their imaging appointment.

Fax: 503-494-4621 (Please allow at least 15 minutes for processing)

REQUIRED FIELDS: PATIENT DEMOGRAPHICS AND PHYSICIAN ORDER INFORMATION

Patient Name: DOB: / / Height: Weight: Phone:	
Referring Physician Name: **Signature:**	
☐ URGENT ☐ ROUTINE	Phone: Fax:
ICD-10 Code(s):	Authorization Number:
ICD-10 Description:	Authorization Dates:
Reason for Exam/Additional Information:	Expected by (date):
	☐ Send images via Cloud

CHECK ALL THAT APPLY

☐ Needs physical assistance: ☐ Wheelchair ☐ Stretcher	☐ Difficult IV start
☐ Needs interpreter. Language:	☐ Port ☐ PICC ☐ Other central line:
☐ Coming from care facility	☐ Patient has a trach ☐ Patient on a ventilator
Facility contact name:	☐ Pregnant, # weeks: Expected due date:
Facility contact number:	☐ Pediatric sedation ☐ Adult general anesthesia
	Anxiolytics needed? *Indicate reason for meds/sedation/GA on page 3.*

MRI (failure to document implants may delay patient care)

Implants

☐ Pacemaker ☐ DBS ☐ Ortho ☐ 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	☐ Arthrogram (must order fluoro. See Gen Rad section) ☐ Left ☐ Right
Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Bilateral
☐ Cardiac (comprehensive and velocity flow w/wo contrast)	Specify joint:
	☐ Extremity: ☐ Left ☐ Right ☐ Bilateral

☐ Other MRI:

CT

☐ CT with contrast ☐ CT without contrast ☐ CT with and without contrast ☐ CTA (CT angiogram) ☐ CT contrast allergy

☐ Brain ☐ Neck ☐ Maxillofacial ☐ Sinus	☐ Weight bearing CT (WBCT) Extremity:
☐ Chest W ☐ Chest WO *(please select one chest study only)*	Laterality: ☐ Left ☐ Right ☐ Bilateral
☐ Abdomen ☐ Pelvis	☐ Coronary Artery Calcium Score (without contrast)
Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar	☐ Coronary CTA & Calcium Scoring (with & without contrast) & FFR*
Colonography: ☐ Diagnostic ☐ Screening	☐ CTA Screening for Non-Calcified Coronary Plaque w/contrast
☐ Other CT:	

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 (pediatric only)	☐ Joint injection (if ordering Arthrogram, check MRI section and this section) Specify: ☐ X-ray body part: Laterality: ☐ Left ☐ Right ☐ Bilateral Specific views and numbers:

ULTRASOUND

☐ Abdomen ☐ Pelvis & transvaginal ☐ Thyroid ☐ Kidney and bladder ☐ Testes ☐ Liver ☐ Liver with elastography ☐ Soft tissue head and neck ☐ LE and UE nonvascular ☐ Paras ☐ Thoras ☐ US fine needle aspirate tissue with guidance **Axilla:** ☐ Left ☐ Right ☐ Bilateral	☐ US pregnant uterus less than 14 weeks gestation ☐ OB transvaginal Other US:

VASCULAR

☐ Upper extremity ☐ Lower extremity ☐ Right ☐ Left ☐ Axilla ☐ Finger(s) ☐ Toe(s)	☐ Arterial Duplex ☐ Carotid Artery ☐ Temporal Artery ☐ PPGs ☐ Graft Flow ☐ Venous Duplex ☐ Vein Mapping ☐ Transcranial Doppler ☐ Dialysis Graft Eval ☐ Venous Reflux study ☐ Laser Doppler ☐ Raynaud's Cold Challenge ☐ ABIs with 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 signs of acute respiratory process or lung cancer?		☐ YES (stop) ☐ NO (continue)
Has the patient had previous chest CT scans?		☐ Yes | Prior location: ☐ No
Patients Current Smoking Status:		☐ Current smoker ☐ Former smoker ☐ Smoker, status unknown
If Former Smoker: Number of years ago patient 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 shared decision making?		☐ Yes ☐ No (required prior to baseline screening)
Did the patient receive cessation guidance?		☐ Yes ☐ No (required prior to baseline screening)

☐ CT Chest Cancer Screening Baseline or Annual ☐ CT Chest Lung Cancer Screening follow up: 1, 3, or 6 month

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 patient 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/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 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.