Physician Order Form – Imaging Services

OREGON HEALTH & SCIENCE UNIVERSITY OHSU

Diagnostic Imaging Services
3181 S.W. Sam Jackson Park Road, Portland OR 97239
Phone: 503-418-0990 Fax: 503-494-4621

Date: ____/____/____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Phone: _____ ❑ Please call Patient ❑ Patient will call to schedule

ICD 9 Code: _____ Authorization #: _____

Reason for Exam: _____

REQUESTING PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Referring Physician Signature: _____

Results (check all that apply):
❑ E-mail report: (e-mail) _____ ❑ CD with Images
❑ Fax report: (fax #) _____ ❑ Special Request:
❑ Phone Report: (phone #) _____ _____

EXAM	FOCUS
❑ **MRI** ❑ w/ contrast ❑ wo/ contrast ❑ w/wo contrast	❑ Brain MRI ❑ Brain MRA ❑ Neck MRI ❑ Neck MRA ❑ Cervical Spine ❑ Thoracic ❑ Lumbar ❑ Extremity (specify): _____ ❑ Other (specify): _____ ❑ Vagal Nerve Stimulator: Program both generator output current and magnet output current to OMA prior to the MRI procedure. After MRI is completed, re-program device to original settings.
❑ **CT** ❑ w/ contrast ❑ wo/ contrast ❑ w/wo contrast	❑ Brain ❑ Sinus ❑ Chest ❑ Abdomen ❑ Pelvis ❑ Cervical Spine ❑ Thoracic ❑ Lumbar ❑ Extremity (specify): _____ ❑ Other (specify): _____
❑ **Mammogram**	❑ Diagnostic ❑ Screening ❑ Others (specify): _____
❑ **Ultrasound**	❑ Abdomen ❑ Pelvis ❑ OB/GYN ❑ Other (specify): _____
❑ **Nuclear Medicine**	❑ Bone ❑ SPECT ❑ Thyroid ❑ Liver – Spleen
❑ **PET/CT**	❑ Head/Neck ❑ Lung ❑ Breast ❑ Lymphoma ❑ Other (specify): _____
❑ **General Radiology**	❑ Barium Enema (please select): ○ With air contrast ○ Without air contrast ❑ I.V. Pyelogram ❑ Upper G.I. (please select): ○ With small bowel series ○ Without small bowel series ❑ Voiding Cystourethrogram ❑ X-ray (specify): _____ ❑ Fluoro Other (specify): _____
❑ **Vascular Lab** ❑ Upper Extremity ❑ Lower Extremity ❑ Finger ❑ Toe(s) ❑ Right ❑ Left	❑ Peripheral Arial Exam ❑ Venous ❑ Chronic Venous Exam ❑ PPG's ❑ Transcranial Doppler ❑ Carotid ❑ Temporal Artery ❑ ABI's with waveform ❑ Nielsen Cold Challenge ❑ Graft Flow ❑ Arterial Duplex ❑ Dialysis Graft Eval. ❑ Abdomen (please select): ○ Renal ○ Mesenteric ○ Portal Hepatic ○ AAA ○ Renal Transplant ❑ Other (specify): _____
❑ **Other**	❑ Specify: _____

Rev 01/08

Scan to PO-7070

Form also available at **www.ohsuhealth.com/provider**

PATIENT PREPARATION (Please follow carefully)	
All Exams with Oral Contrast	Nothing to eat or drink 2 hours prior to exam.
Barium Enema/Air Contrast	Please call 503-418-0990 for instructions.
CT	If you are allergic to iodine or CT contrast or think you might be pregnant, or if you have any questions, please call 503-418-0990.
I.V. Pyelogram (Kidney X-ray)	Please call 503-418-0990 for instructions.
Mammogram	Do not wear powder, deodorant, or lotion.
MRI	If you have had difficulty completing a prior MRI exam, please call 503-418-0990.
Nuclear Medicine Scan	Bone Scan or Cardiac Stress Test: instructions will be mailed to you. Other Tests: Call 503-494-8468 for instructions.
PET/CT	Diet and activity restrictions apply. If you are allergic to iodine, please call 503-418-0990.
Ultrasound	Abdomen: Nothing to eat or drink after 12 midnight the evening prior to the exam. OB/GYN: • Drink 32 ounces of water one hour prior to the exam. • Do not use the restroom until the exam is completed.
Upper G.I. – Small Bowel Series	Nothing to eat or drink after 12 midnight the evening prior to the exam. Refrain from chewing gum or smoking until the exam is complete.
Vascular Lab	Abdomen: Nothing to eat or drink after 12:00 midnight the evening prior to the exam.
Voiding Cystourethrogram (Bladder Study)	No preparation is necessary. If you are allergic to iodine or CT contrast or if you have any questions, please call 503-418-0990.

PLEASE REMIND THE PATIENT of the following:

- Please bring their insurance card to their imaging appointment. Please also remind them to bring a list of their current medications including the dose of the medication and how often they are taking the medication.
- Some contrast exams require a BUN/Creatinine prior to exam.
- If there are any questions about the exam they will be having, please call 503-418-0990.

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.

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Scheduling: 503-418-0990 Fax: 503-494-4621
Customer Service Manager: 503-418-4969