Physician Order Form for Molecular Imaging and Therapy

FAX completed form to: 503-494-2879 Molecular Imaging and Therapy 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	**Phone Number: _____**
☐ Radiology to call patient to schedule exam	**Fax Number: _____**
NPI:_____	**Authorization Number: _____**
Office Contact: _____	**Authorization Dates: _____- _____**
ICD-10 Code(s):	**Prior PET/CT Exam: ☐ Yes ☐ No**
Diagnosis:	**Pregnant: ☐ Yes ☐ No ☐ N/A**

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

Molecular Imaging
Please indicate one or more exams:

☐ Bone Scan: **☐3 Phase ☐Whole Body**
☐Limited Area SPECT
Location(s):_____
☐ Brain SPECT or ☐ DaTscan
☐ Cisternogram – Please also order Lumbar Puncture
☐ Gastric Emptying Study - **☐Solid ☐Liquid ☐Both**
☐ HIDA - **☐with EF ☐without EF**
☐ Liver Spleen w/Vascular Flow
☐ Lung Perfusion **☐with Ventilation**
☐ Lymphoscintigraphy
☐ Mag3 Renal Scan w/Vascular Flow & Function
☐ w/o Lasix
☐ Meckels
☐ MIBG ☐ MSA

☐ Myocardial Perfusion - **☐Exercise ☐Pharmacologic**
☐ Multiple studies ☐Single study - Rest
☐ MUGA
☐ Parathyroid
☐ Cardiac Amyloidosis
☐ Red Blood Cell
☐ Thyroid Uptake Scan
☐ White Blood Cell
☐ Other: _____
Diagnosis/ICD-10 Code(s) for Scan(s):

Additional clinical history and symptoms:

Physician Signature: _____(MD, DO, NP, PA) Date: _____

Preferred Location: ☐ Portland Main Campus – Marquam Hill ☐ Portland South Waterfront – Center for Health and Healing (if available)

Additional information and questions below:
Confirm pregnancy status.
Please indicate height and weight on order form.
SPECT/CT table limit is 450lbs.

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 Molecular Imaging and Therapy scheduling at 503-494-8468 to schedule their imaging.
• Molecular Imaging and Therapy can also be reached by email: nucmed@ohsu.edu
• 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: 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 patient plans to take public/private transportation, they must have a responsible adult with them.
• 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.