

# Physician Order Form for Imaging Services

Diagnostic Imaging Services 3181 SW Sam Jackson Park Road, Portland OR 97239

Radiology Scheduling: 503-418-0990 Fax: 503-494-4621



## REQUIRED FIELDS: Patient Demographics and Physician Order Information

**Patient Name:** \_\_\_\_\_ **DOB:** / / **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

<input type="checkbox"/> URGENT <input type="checkbox"/> ROUTINE <b>ICD-10 Code(s):</b> _____ <b>ICD-10 Description:</b> _____ Additional Information: _____ _____	Phone #: _____ Fax #: _____ Authorization Number: _____ Authorization Dates: _____ - _____ Expected by (date): _____ <input type="checkbox"/> Mail CD of Images (Complete pg. 2) <i>Results always faxed</i>
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### Check all that apply

<input type="checkbox"/> Needs physical assistance: _____ <input type="checkbox"/> Needs interpreter. Language: _____ <input type="checkbox"/> Coming from Care Facility Facility contact name: _____ Facility contact number: _____	<input type="checkbox"/> Difficult IV Start <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Other central line: _____ <input type="checkbox"/> Patient has a trach <input type="checkbox"/> Patient on a ventilator <input type="checkbox"/> Pregnant - # Weeks: _____ <input type="checkbox"/> Pediatric Sedation <input type="checkbox"/> Adult General Anesthesia Anxiolytics Needed? <b>Indicate reason for meds/sedation/GA on Pg 2.</b>
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### MRI (failure to document implants may delay patient care)

<b>Implants</b>	<input type="checkbox"/> Pacemaker <input type="checkbox"/> DBS <input type="checkbox"/> Other Implant: _____    Make/Model/Implant Date: _____ <input type="checkbox"/> 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.
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<input type="checkbox"/> Without Contrast <input type="checkbox"/> With and Without Contrast <input type="checkbox"/> Gadolinium allergy <input type="checkbox"/> On Dialysis  <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Brain <b>Spine:</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Cardiac (comprehensive and velocity flow w/wo contrast)	<input type="checkbox"/> Arthrogram (Must order fluoro, see Gen Rad section) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral Specify Joint: _____ <input type="checkbox"/> Extremity: _____ <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral
<input type="checkbox"/> Other MRI:	

### CT

<input type="checkbox"/> CT With Contrast <input type="checkbox"/> CT Without Contrast <input type="checkbox"/> CT With & Without Contrast <input type="checkbox"/> CTA (CT Angiogram) <input type="checkbox"/> CT Contrast Allergy <input type="checkbox"/> CT Chest WO Contrast for Lung Follow Up (This order is for a 1-6 month follow-up to a lung screening study)	
<input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Sinus <input type="checkbox"/> Chest W <input type="checkbox"/> Chest WO <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <b>Spine:</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <b>Colonography:</b> <input type="checkbox"/> Diagnostic <input type="checkbox"/> Screening <input type="checkbox"/> Other CT:	<input type="checkbox"/> Weight Bearing CT (WBCT) Extremity _____ Laterality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Coronary Artery Calcium Score (without contrast) <input type="checkbox"/> Coronary CTA & Calcium Scoring (with & without contrast) & FFR* <input type="checkbox"/> CTA Screening for Non-Calcified Coronary Plaque w/contrast
<input type="checkbox"/> CT Lung Cancer Screening (Questions on reverse must be filled out and received in addition to order form)	

### GENERAL RADIOLOGY

<input type="checkbox"/> Barium Enema <input type="checkbox"/> Barium Enema With Air contrast <input type="checkbox"/> Upper GI <input type="checkbox"/> UGI with Small Bowel Series <input type="checkbox"/> Esophogram <input type="checkbox"/> Myelogram <input type="checkbox"/> Lumbar Puncture** <input type="checkbox"/> Voiding Cystourethrogram <input type="checkbox"/> VCUG with sedation	<input type="checkbox"/> Joint injection (if ordering Arthrogram, check MRI section and this section) (specify) : _____ <input type="checkbox"/> X-ray Body part: _____ Laterality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral Specific Views & #:
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### ULTRASOUND

<input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Kidney and Bladder <input type="checkbox"/> Thyroid <input type="checkbox"/> Testes <input type="checkbox"/> Head  <b>Axilla:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	<input type="checkbox"/> US Pregnant Uterus less than 14 weeks gestation <input type="checkbox"/> OB US 14 weeks, Fetus <input type="checkbox"/> OB Transvaginal  Other US :
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### VASCULAR

<input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Finger(s) <input type="checkbox"/> Toe(s)	<table style="width: 100%;"> <tr> <td><input type="checkbox"/> Arterial Duplex</td> <td><input type="checkbox"/> Carotid Artery</td> <td><input type="checkbox"/> Temporal Artery</td> <td><input type="checkbox"/> PPG's</td> <td><input type="checkbox"/> Graft Flow</td> </tr> <tr> <td><input type="checkbox"/> Venous Duplex</td> <td><input type="checkbox"/> Vein Mapping</td> <td><input type="checkbox"/> Transcranial Doppler</td> <td><input type="checkbox"/> Dialysis Graft Eval</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Venous Reflux study</td> <td><input type="checkbox"/> Laser Doppler</td> <td><input type="checkbox"/> Raynaud's Cold Challenge</td> <td><input type="checkbox"/> ABI's w/ waveform</td> <td></td> </tr> </table> <b>Abdomen:</b> <input type="checkbox"/> AAA <input type="checkbox"/> Mesenteric <input type="checkbox"/> Portal Hepatic <input type="checkbox"/> Renal <input type="checkbox"/> Renal Transplant	<input type="checkbox"/> Arterial Duplex	<input type="checkbox"/> Carotid Artery	<input type="checkbox"/> Temporal Artery	<input type="checkbox"/> PPG's	<input type="checkbox"/> Graft Flow	<input type="checkbox"/> Venous Duplex	<input type="checkbox"/> Vein Mapping	<input type="checkbox"/> Transcranial Doppler	<input type="checkbox"/> Dialysis Graft Eval		<input type="checkbox"/> Venous Reflux study	<input type="checkbox"/> Laser Doppler	<input type="checkbox"/> Raynaud's Cold Challenge	<input type="checkbox"/> ABI's w/ waveform	
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**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.
- Ordering a CT Chest WO Contrast for LDCT Follow Up? See CT section above.

Patient is <b>on Medicare AND</b> between the age of <b>50-77</b>	OR	<input type="checkbox"/> YES (Continue)	<input type="checkbox"/> NO (STOP)
Patient is between the age of <b>50-80</b>		<input type="checkbox"/> YES (Continue)	<input type="checkbox"/> NO (STOP)
Does patient show any signs or symptoms of lung cancer?		<input type="checkbox"/> YES (STOP)	<input type="checkbox"/> NO (Continue)
Is this the first (baseline) CT or an annual exam?	<input type="checkbox"/> First Screening <input type="checkbox"/> Annual Screening   Prior Location:		
Patients Current Smoking Status	<input type="checkbox"/> Current smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Smoker, status unknown		
<b>If Former Smoker:</b> Number of years ago pt. 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 share decision making?	<input type="checkbox"/> YES <input type="checkbox"/> NO	(required prior to baseline screening)	
Did the patient receive cessation guidance?	<input type="checkbox"/> YES <input type="checkbox"/> NO	(required prior to baseline screening)	

**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 pt 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/aesthesia 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 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.*