General Imaging Order Form

TODAY'S DATE: _____

OREGON IMAGING CENTERS

General Scheduling: (541) 334-7555 • TF: (888) 968-7608
Fax Orders: (541) 334-7564 (Please call after sending a STAT Order)
Online Orders: forms.oregonimaging.com/general-order-form

SPECIAL REPORTING/SCHEDULING INSTRUCTIONS

☐ Urgent Scheduled (within 2-3 days) ☐ STAT Scheduled/Resulted (not called)
☐ STAT call to provider (requires direct number to ordering provider)
Ordering provider cell# _____
***All other orders are handled on a routine basis**

Patient Last Name (Required) First Middle	Date Of Birth (Required) Patient Daytime Phone
Ordering Clinician (Required) Office Location (If Multiple)	Clinician Signature (Required - No Stamps) Date
Insurance PA#	Send Additional Copies Of Report To
Symptoms / Diagnosis / History (Required) - Include Icd-Code(S)	

If the exam you need is not listed, please choose themodality and write in the exam description.
☐ X-Ray ☐ Fluoro/Diagnostics ☐ MRI ☐ MRA ☐ CT ☐ CTA ☐ US Exam Description: _____

X-RAY No appointment neccesary

- ☐ Skull
- ☐ Abdomen 2 View w/ CXR ☐1V ☐3View
- ☐ Facial Bones
- ☐ Chest 1 View (Positive PPD)
- ☐ Chest 2 Views
- ☐ Ribs w/PA Chest ☐L ☐R
- ☐ Ribs w/PA Chest & LAT Chest ☐L ☐R
- ☐ Abdomen (KUB)
- ☐ Abdomen 2 View w/ CXR ☐PA ☐PA/LAT
- ☐ Bone/Skeletal Survey (Scheduled Exam)
- ☐ Sacroiliac Joints
- ☐ Pelvis

SPINE

- ☐ C-Spine (choose one)
  ☐ Routine ☐ 3V ☐ Flex/Ext ☐ Routine w/ Flex/Ext
- ☐ T-Spine
- ☐ L-Spine ☐W/Obl ☐W/Flex/Ex
- ☐ Thoracolumbar 2V
- ☐ Scoliosis Survey
- ☐ Sacrum & Coccyx

EXTREMITY

	L	R	3-View
☐ Shoulder	☐	☐	
☐ Humerus	☐	☐	
☐ Clavicle	☐	☐	
☐ Elbow	☐	☐	
☐ Forearm	☐	☐	
☐ Wrist	☐	☐	
☐ Hand	☐	☐	
☐ Femur	☐	☐	
☐ Knee	☐	☐	☐
☐ Tib/Fib	☐	☐	
☐ Ankle	☐	☐	
☐ Foot	☐	☐	
☐ Calcaneus	☐	☐	
☐ Fingers Digit#___	☐	☐	
☐ Toes Digit#___	☐	☐	
☐ Hip Unilateral with Pelvis	☐	☐	
☐ Hip Bilateral with Pelvis	☐	☐	
☐ Hands & Wrists Arthritis Survey	☐	☐	

FLUORO / DIAGNOSTICS

- ☐ VCUG
- ☐ Lumbar Puncture
- ☐ Joint Injection ☐L ☐R
  Specify joint(s) and list medications
  _____
- ☐ Joint Aspiration ☐L ☐R
  Specify joint(s) to be aspirated Lab Order Required

PET / CT

Special order form required, call 541-681-8588
or click here to download the form.

MRI

Contrast Choice

- ☐ At Radiologist's Discretion
- ☐ WO ☐ W/WO ☐ W (rare exam)
- ☐ Brain
- ☐ Brain Attention Orbits
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Breast (See Breast Imaging Section)
- ☐ Pelvis
- ☐ Pelvis for Sacrum/Coccyx
- ☐ Abdomen L R
- ☐ Shoulder ☐ ☐
- ☐ Elbow ☐ ☐
- ☐ Wrist ☐ ☐
- ☐ Hip ☐ ☐
- ☐ Knee ☐ ☐
- ☐ Ankle ☐ ☐
- ☐ Foot ☐ ☐
- ☐ Arthrogram (Specific) Site _____

MR ANGIOGRAM

- ☐ Brain (Circle of Willis)
- ☐ Neck (Carotids)
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis _____

CT

Contrast Choice

- ☐ At Radiologist's Discretion
- ☐ WO ☐ W/WO ☐ W
- ☐ Brain
- ☐ Maxillofacial
- ☐ Sinus-Limited
- ☐ Sinus-Complete
- ☐ Neck Soft Tissue
- ☐ Chest
- ☐ Abdomen (Specific Organ) _____
- ☐ Abdomen/Pevis
- ☐ KUB (Abdomen/Pelvis for Stones)
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Myelogram (Specific Site)
- ☐ Upper Ext – Site _____ ☐L ☐R
- ☐ Lower Ext – Site _____ ☐L ☐R
- ☐ Arthrogram – (Specific) _____ ☐L ☐R

CT ANGIOGRAM

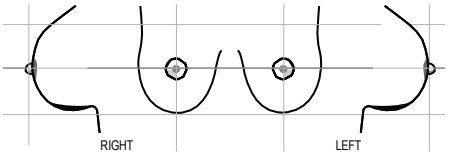
- ☐ CTA-Brain
- ☐ CTA-Neck
- ☐ CTA-Chest
- ☐ CTA-Chest for PE
- ☐ CTA-Renal
- ☐ CTA-Abdomen with Pelvis
- ☐ CTA-Abdomen with Runoff

ULTRASOUND / DOPPLER

- ☐ Thyroid
- ☐ Carotid Doppler
- ☐ AAA Doppler (Symptomatic) AAA
- ☐ Abdomen complete with duplex
- ☐ Abdomen complete with Portal Vein Doppler
- ☐ Abdomen limited (Organ/Quadrant/Abd wall)
- ☐ Dialysis graft Doppler
- ☐ Pelvis with Transvaginal (Doppler if needed)
- ☐ Pelvis only (Doppler if needed)
- ☐ Transvaginal only (Doppler if needed)
- ☐ OB < 14 wks (with Transvaginal if Indicated)
- ☐ OB > 14 wks (with Transvaginal if Indicated)
- ☐ Renal
- ☐ Renal with Doppler Blood Flow
- ☐ Scrotum (with Ltd Doppler if Needed)
- ☐ Infant Hips
- ☐ Shoulder
- ☐ Venous Doppler Arm ☐L ☐R
- ☐ Venous Doppler Leg ☐L ☐R
- ☐ PRP ☐L ☐R

BREAST IMAGING

Indicate Location of Abnormality:



- ☐ Screening Mammogram (No Breast Symptoms)
- ☐ Diagnostic Mammogram with US if Indicated
- ☐ Additional Views (Follow Up) with US if indicated
- ☐ Ultrasound Breast ☐L ☐R
- ☐ Breast Biopsy (Choose One) ☐L ☐R
  ☐ At Radiologist Discretion ☐ Stereo ☐ US ☐ MRI
- ☐ MRI Breast (Select Below)
  ☐ Implant Integrity ☐ Lesion Detected ☐ Pre-op

Please Choose One:

- ☐ Radiologist may order additional imaging, if needed.
- ☐ Call my office prior to additional studies.

DEXA

- ☐ Female Post Menopausal
- ☐ F/U to monitor response to osteoporosis drug therapy.
- ☐ Other Qualifying Reason (ICD Code) If high-risk medications, please also give Primary Diagnosis