Pediatric Imaging Order Form

OREGON IMAGING CENTERS

Today's Date: _____

General Scheduling: (541) 334-7555 ♦ TF: (888) 968-7608

Fax Orders: (541) 334-7564

Online Orders: *https://forms.oregonimaging.com/general-order-form*

REPORTING INSTRUCTIONS

☐ ASAP Scheduled

*As an outpatient only facility we do not perform true STAT exams, if the need is emergent please consider referring patient to an Emergency Department or Urgent Care facility.

PATIENT LAST NAME **(REQUIRED)** FIRST M	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 10 CODE(S)		

If the exam you need is not listed, please choose the modality and write in the exam description.

☐ X-Ray ☐ Fluoro/Diagnostics ☐ MRI ☐ CT ☐ US *Exam Description:* _____

X-RAY NO APPOINTMENT NECESSARY

- ☐ Skull (Complete)
- ☐ Skull (Limited)
- ☐ Facial Bone
- ☐ Sinus (Limited)
- ☐ Chest (PA/LAT)
- ☐ Abdomen 1V
- ☐ Abdomen 2V
- ☐ Abdomen 2V with 1V Chest
- ☐ Abdomen 2V with 2V Chest
- ☐ Infant Trauma < 1 year
- ☐ Infant Trauma > 1 year
- ☐ Bone Age
- ☐ Foreign Body Study
- ☐ Soft Tissue Neck
- ☐ Pelvis

Spine

- ☐ C-Spine 3V
- ☐ C-Spine 5V (w/obliques)
- ☐ T-Spine
- ☐ L-Spine
- ☐ Thoracolumbar 2V
- ☐ Lumbar
- ☐ Scoliosis Survey
- ☐ Sacrum & Coccyx

Extremity	L	R
☐ Shoulder	☐	☐
☐ Humerus	☐	☐
☐ Clavicle	☐	☐
☐ Elbow	☐	☐
☐ Forearm	☐	☐
☐ Wrist	☐	☐
☐ Hand	☐	☐
☐ Femur	☐	☐
☐ Knee	☐	☐
☐ Tib/Fib	☐	☐
☐ Ankle	☐	☐
☐ Foot	☐	☐
☐ Fingers Digit #___	☐	☐
☐ Toes Digit #___	☐	☐
☐ Hip Unilateral w/ Pelvis	☐	☐
☐ Hip Bilateral w/ Pelvis	☐	☐

FLUORO/DIAGNOSTICS

- ☐ VCUG

DEXA

- ☐ Diagnostic DEXA

MRI

Contrast Choice

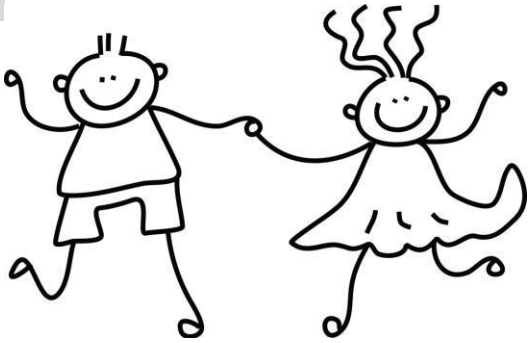
- ☐ **At Radiologist Discretion**
- ☐ **WO** ☐ **W/WO** ☐ **W (rare exam)**
- ☐ Brain
- ☐ C-Spine
- ☐ L-Spine
- ☐ Pelvis
- ☐ Abdomen
- ☐ Knee (Left)
- ☐ Knee (Right)

CT

Contrast Choice

- ☐ **At Radiologist Discretion**
- ☐ **WO** ☐ **W** ☐ **W/WO**
- ☐ Brain
- ☐ Abdomen
- ☐ Abdomen/Pelvis W/ Contrast (Appendicitis)
- ☐ Abdomen/Pelvis W/O Contrast (KUB/Renal Stone)
- ☐ Pelvis
- ☐ Leg Length (CT Scanogram)

ULTRASOUND/DOPPLER

- ☐ Infant Head < 1 year
- ☐ Soft Tissue Head or Neck
- ☐ Breast
- ☐ Chest for Soft Tissue
- ☐ Abdomen Complete
- ☐ Abdomen Ltd (Appendicitis)
- ☐ Abdomen Ltd (Pyloric Stenosis)
- ☐ Pelvis (No Transvag)
- ☐ Pelvis (with TV if Indicated)
- ☐ Renal Complete
- ☐ Infant Hips W/ Manipulation < 1 Year
- ☐ Infant Hips W/O Manipulation < 1 Year
- ☐ Scrotum with Ltd Doppler/Blood Flow if Indic.

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