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500 NE Multnomah St., Suite 100, Portland, OR 97232.

Specialty Imaging Order Form

Regional Imaging Services

Today's date: ______________________________

PATIENT NAME: *(last, first)*

HEALTH RECORD NO.: | **DOB:** | **GENDER:**

REASON FOR EXAM:

PERTINENT MEDICAL INFO: *(e.g. patient weight, allergies, lab, LMP)*

☐ IP Inpatient room No.: ____________ ☐ OP ☐ ED ER Room No.: ____________

PROVIDER NPI (UPIN):

ORDERING/REFERRING CLINICIAN: *(please print)*

OFFICE PHONE/FAX: | **CC:**

SIGN OR SYMPTOM/DIAGNOSIS: *(Please note: sign or symptom necessitating the reason for the visit must be provided before rendering the service…Do not include a 'rule-out' diagnosis). When ordering multiple tests on the same order form, please indicate a sign or symptom for each test/treatment.*

ICD-10 CODE: | **ORDER PRIORITY:** ROUTINE WITHIN 1 WEEK URGENT STAT

	MAGNETIC RESONANCE (MR)			
	BRAIN	WO	W	W/WO
	ORBITS	WO	W	W/WO
	CERVICAL SPINE	WO	W	W/WO
	THORACIC SPINE	WO	W	W/WO
	LUMBAR SPINE	WO	W	W/WO
	MRA	WO	W	W/WO
	A. INTRACRANIAL	WO	W	W/WO
	B. EXTRACRANIAL	WO	W	W/WO
	SOFT TISSUE NECK	WO	W	W/WO
	CHEST	WO	W	W/WO
	ABDOMEN/LIVER	WO	W	W/WO
	PELVIS	WO	W	W/WO
	SHOULDER	R	L	B
	ELBOW	R	L	B
	WRIST	R	L	B
	HIP	R	L	B
	KNEE	R	L	B
	ANKLE	R	L	B
	MR ARTHROGRAPHY			
	BREAST	R	L	B
	IAC	WO	W	W/WO
	PITUITARY	WO	W	W/WO
	TMJ	WO	W	W/WO
	OTHER:			

	FLUOROSCOPY
	BARIUM ENEMA
	UPPER GI
	ESOPHAGRAM
	SMALL BOWEL FOLLOW THROUGH
	IVP (XRAY)/IVP WITH TOMO
	HYSTEROGRAM
	VCUG (XRAY)
	OTHER:

	MAMMOGRAPHY			
	SCREENING	R	L	B
	DIAGNOSTIC	R	L	B

	ULTRASOUND			
	BREAST	R	L	B
	RENAL			
	HIP (INFANT)			
	ABD COMPLETE			
	ABD LIMITED			
	A. RUQ			
	B. LIVER			
	C. SPLEEN			
	D. OTHER			
	PELVIS/VAG			
	OB COMPLETE			
	OB LIMITED			
	A. OB ANATOMY SCREEN (18 – 20 WKS GA)			
	B. OB GROWTH/FOLLOW UP			
	C. OB LTD (SPECIFY) ____________			
	D. OB LATE REGISTRANT (>22 WKS GA)			
	CAROTID DOPPLER			
	ARTERIAL DOPPLER EXTREMITY	R	L	B
	A. UPPER	OR		B. LOWER
	VENOUS DOPPLER	R	L	B
	A. UPPER	OR		B. LOWER
	THYROID			
	SCROTAL			
	FOLLICULAR			
	A. ANTRAL SCAN CYCLE DAY 2-6			
	B. PREOVULATORY SCAN CYCLE DAY 12			
	OTHER:			

	NUCLEAR MEDICINE
	THYROID I 123 UPTAKE & SCAN
	BONE SCAN
	MUGA SCAN
	HIDA SCAN
	GASTRIC EMPTYING SCAN
	LUNG SCAN - VENT & PERF
	I 131 WHOLE BODY THYROID
	MYOCARDIAL PERFUSION
	PET/CT
	A. ROUTINE (HEAD TO PELVIS)
	B. WHOLE BODY (TOP OF HEAD TO TOES)
	OTHER:

	BONE DENSITY EXAM (DEXA SCAN)
	PRIMARY SCREENING
	SECONDARY SCREENING
	OSTEOPOROSIS MANAGEMENT (FOLLOW UP)

	CT SCAN			
	ABDOMEN	WO	W	W/WO
	PELVIS	WO	W	W/WO
	CHEST	WO	W	W/WO
	SINUS	LIMITED	OR	FULL
	BRAIN	WO	W	W/WO
	SOFT TISSUE NECK	WO	W	W/WO
	HIP	WO	W	W/WO
	CERVICAL SPINE LEVEL:			
	THORACIC SPINE LEVEL:			
	LUMBAR SPINE			
	CT ARTHOGRAPHY			
	OTHER:			

ORDERING CLINICIAN'S SIGNATURE: *(no stamps)*

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