

# PHYSICIAN'S REQUEST

## FOR DIAGNOSTIC TESTING



3003 N. Delta Hwy., Ste. 303  
Eugene, OR 97408

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ WVI Chart # \_\_\_\_\_

Patient's Home # \_\_\_\_\_ Work or Cell # \_\_\_\_\_

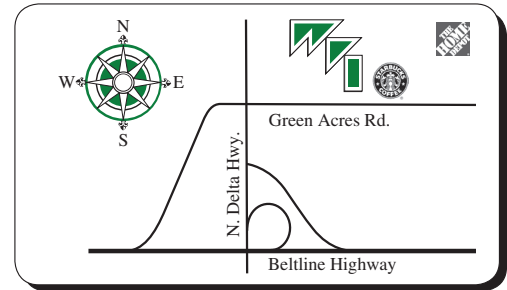
Date of Exam \_\_\_\_\_ Time \_\_\_\_\_ am pm

Dx Code \_\_\_\_\_

Diagnosis/Symptoms \_\_\_\_\_

Avoid "Rule-Out"

Please indicate if order can be modified at Radiologists' discretion



### 3T HIGH FIELD MRI

### CT

	W/O Contrast Material	W/O and W/ Contrast Material
Brain	<input type="checkbox"/>	<input type="checkbox"/>
MRA Brain	<input type="checkbox"/>	
MRA Neck	<input type="checkbox"/>	<input type="checkbox"/>
Orbit/Face/Neck	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity Joint	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremity Joint	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Bi
Hip	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Bi
Knee	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Bi
Other:		

	W/O Contrast Material	W/ Contrast Material
Head or Brain	<input type="checkbox"/>	<input type="checkbox"/>
Orbit	<input type="checkbox"/>	<input type="checkbox"/>
Post Fossa	<input type="checkbox"/>	<input type="checkbox"/>
Inner Ear	<input type="checkbox"/>	<input type="checkbox"/>
Maxillofacial	<input type="checkbox"/>	<input type="checkbox"/>
Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Full Exam	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Screen	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	
Foot	<input type="checkbox"/>	
Multi Planar 2D/3D Reformat		<input type="checkbox"/>
Thorax (Chest)	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen and Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Renal Colic	<input type="checkbox"/>	<input type="checkbox"/>
CTA Head	<input type="checkbox"/>	<input type="checkbox"/>
CTA Neck	<input type="checkbox"/>	<input type="checkbox"/>
CTA Chest	<input type="checkbox"/>	<input type="checkbox"/>
CTA Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>
CTA Abdominal/Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Other:		

#### If Contrast Is Required

Hx Kidney/Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hx Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Over 65	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes please provide creatinine & GFR within one month. Date of Labs \_\_\_\_\_

Creatinine \_\_\_\_\_ GFR \_\_\_\_\_

Please fax copy of labs.

Previous surgery area being scanned?  Yes (Date: \_\_\_\_\_)  No

Hx Cancer?  Yes (Type: \_\_\_\_\_)  No Ambulatory?  Yes  No

Additional information: \_\_\_\_\_

### SCHEDULING

#### Main Number

**541-344-9500**

Please fax this form with **PATIENT DEMOGRAPHICS** to

**541-344-9510**

Previous Films \_\_\_\_\_

Film Location \_\_\_\_\_

#### For MRI

Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_

Pregnant  Yes  No

Claustrophobic  Yes  No

Ear, Eye, Heart or Brain Surgery  Yes  No

Metal in or on Body  Yes  No

Injury to Eye w/Metal  Yes  No

Implants/Prosthesis (IUD, Stent)  Yes  No

Medication Patches  Yes  No

#### For CT

Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_

Pregnant  Yes  No

Hx Iodine Allergy  Yes  No

Hx Kidney Disease  Yes  No

Hx Diabetes  Yes  No

\_\_\_\_ Over 65 \_\_\_\_\_ Bun \_\_\_\_\_ Creatinine

Date of Labs \_\_\_\_\_

Please fax copy of Labs.

**For Referring Physicians:** If your office would like images, please mark method of delivery:  PACS  CDs

Based upon the patient's history, exam and diagnosis, I have requested the above test(s). I hereby certify that these tests were medically necessary for the patient at the time they were scheduled.

Print Physician's Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Additional Copies of Report to \_\_\_\_\_