

# Diagnostic Imaging Order form

## Physician Referral Form



- Legacy Emanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Meridian Park Medical Center
- Legacy Mount Hood Medical Center
- Legacy Salmon Creek Medical Center

**To schedule appointments call:**

**In Oregon:** Phone: 503-413-7800 Fax: 503-413-8899  
**In Washington:** Phone: 360-487-1800 Fax: 360-487-1809

**Patient Information** Date: \_\_\_\_\_ Arrival time: \_\_\_\_\_ Appt: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Wt: \_\_\_\_\_

Symptoms/reason for exam: \_\_\_\_\_

ICD-9/10 code(s): \_\_\_\_\_


Ordering Physician: \_\_\_\_\_ Signature: \_\_\_\_\_

Insurance: \_\_\_\_\_ Pre-Authorization number/date range: \_\_\_\_\_

Physician preference for results:  Report only  Report and CD  Routine  STAT

Fax: \_\_\_\_\_ Other: \_\_\_\_\_

Call report requires cell or back line number: \_\_\_\_\_

<input type="checkbox"/> <b>MRI</b> <input type="checkbox"/> With IV contrast <input type="checkbox"/> Without contrast <input type="checkbox"/> With and without IV contrast	<input type="checkbox"/> Brain MRI <input type="checkbox"/> Brain MRA <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Knee (○ R) (○ L) <input type="checkbox"/> Shoulder (○ R) (○ L) <input type="checkbox"/> Extremity other ( <i>specify</i> ) _____ <input type="checkbox"/> Check box if claustrophobic <input type="checkbox"/> Conscious sedation/anesthesia requested <input type="checkbox"/> Other ( <i>specify</i> ) _____ Creatinine _____ GFR _____ Date _____
<input type="checkbox"/> <b>CT</b> <input type="checkbox"/> With IV contrast <input type="checkbox"/> Without contrast <input type="checkbox"/> With and without IV contrast	<input type="checkbox"/> Head CT <input type="checkbox"/> Sinus <input type="checkbox"/> Spine: (○ Cervical ○ Thoracic ○ Lumbar) <input type="checkbox"/> CTA ( <i>specify</i> ) _____ <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal colic <input type="checkbox"/> Urogram <input type="checkbox"/> Cardiac <input type="checkbox"/> With calcium score <input type="checkbox"/> Extremity ( <i>specify</i> ) _____ <input type="checkbox"/> Other ( <i>specify</i> ) _____ Creatinine _____ GFR _____ Date _____
<input type="checkbox"/> <b>Radiology</b>	<input type="checkbox"/> Chest (PA/lateral) <input type="checkbox"/> Chest (1 view) <input type="checkbox"/> Acute abdomen (2 view abd + 1 view cxr) <input type="checkbox"/> KUB <input type="checkbox"/> C spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine additional views: _____ <input type="checkbox"/> Extremity/joint ( <i>specify</i> ) _____ ○ Right or ○ Left <input type="checkbox"/> Other _____
<input type="checkbox"/> <b>Fluoroscopy</b>	<input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI <input type="checkbox"/> Small bowel follow-through <input type="checkbox"/> Video swallowing study <input type="checkbox"/> Barium enema (○ with air) <input type="checkbox"/> VCUG <input type="checkbox"/> Myelogram: (○ Cervical ○ Thoracic ○ Lumbar) <input type="checkbox"/> Lumbar puncture ( <i>specify labs</i> ) _____ <input type="checkbox"/> Arthrogram ( <i>specify joint</i> ) _____ <input type="checkbox"/> Joint injection _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Ultrasound</b>	<input type="checkbox"/> Complete abdomen <input type="checkbox"/> Limited abdomen ( <i>specify</i> ) _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> OB <input type="checkbox"/> Renal <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid <input type="checkbox"/> Thyroid FNA <input type="checkbox"/> Carotid <input type="checkbox"/> AAA <input type="checkbox"/> Venous (DVT) <input type="checkbox"/> Lower extremity (○ Right ○ Left ○ Bilateral) <input type="checkbox"/> Arterial <input type="checkbox"/> Upper extremity (○ Right ○ Left ○ Bilateral) <input type="checkbox"/> US PVS <input type="checkbox"/> ABI only <input type="checkbox"/> Full peripheral <input type="checkbox"/> Lower extremity (○ Right ○ Left ○ Bilateral) <input type="checkbox"/> Upper extremity (○ Right ○ Left ○ Bilateral) <input type="checkbox"/> Other _____
<input type="checkbox"/> <b>Nuclear Medicine</b>	<input type="checkbox"/> Whole body bone scan <input type="checkbox"/> Thyroid uptake + scan <input type="checkbox"/> MUGA *with SPECT ( <i>specify</i> ) _____ <input type="checkbox"/> Gastric emptying (○ Solid ○ Liquid ○ Both) <input type="checkbox"/> 3 phase bone scan <input type="checkbox"/> HIDA <input type="checkbox"/> HIDA (with ejection fraction) *with SPECT ( <i>specify</i> ) _____ <input type="checkbox"/> Renal scan (○ Lasix ○ MAG3 ○ DPTA) <input type="checkbox"/> Multiple areas bone scan <input type="checkbox"/> Myocardial perfusion (○ Treadmill ○ Pharmacological) *with SPECT ( <i>specify</i> ) _____ <input type="checkbox"/> Other ( <i>specify</i> ) _____ <input type="checkbox"/> PET/CT ( <i>specify</i> ) _____
<input type="checkbox"/> <b>Breast Imaging</b>	<input type="checkbox"/> Screening mammogram <input type="checkbox"/> Breast ultrasound only <input type="checkbox"/> Diagnostic mammogram <input type="checkbox"/> Breast ultrasound and biopsy if indicated <input type="checkbox"/> Breast MRI <div style="text-align: right; margin-top: 10px;">  </div> <p style="text-align: center; margin-top: 5px;"><i>Please complete diagram and provide indications for all diagnostic studies</i></p>
<input type="checkbox"/> <b>DEXA</b>	<input type="checkbox"/> Hip/lumbar <input type="checkbox"/> Forearm/ankle

**Preparations — Please follow carefully. Call the department with any questions.  
(Small amount of water and oral medications permitted.)**

<b>Upper G.I./Small Bowel Series</b>	<ul style="list-style-type: none"> <li>• Nothing to eat or drink after midnight for a.m. appointment</li> <li>• Nothing to eat or drink 8 hours before p.m. appointment</li> <li>• Please note: Upper G.I. may take 1 hour, small bowel exam may take several hours</li> </ul>
<b>Barium Enema</b>	<ul style="list-style-type: none"> <li>• Pick up an EZH Colonic Prep Kit at your pharmacy 2 days prior to exam</li> <li>• Night before your exam: Take 4 Dulcolax or Bisacodyl tablets at 4 p.m. and drink only clear liquids</li> <li>• 4 hours prior to exam: Do not eat or drink</li> </ul>
<b>CT</b>	<ul style="list-style-type: none"> <li>• Nothing to eat for 4 hours prior to exam</li> <li>• Nothing to drink for 2 hours prior to exam</li> </ul>
<b>Mammogram</b>	<ul style="list-style-type: none"> <li>• Do not wear powder, deodorant or lotion around breasts or under arms</li> </ul>
<b>MRI</b>	<ul style="list-style-type: none"> <li>• Claustrophobic patients — contact your physician regarding pre-exam medication. You will need to arrange a ride home.</li> <li>• Abdomen and pelvis: Nothing to eat or drink for 4 hours prior to exam</li> <li>• Anesthesia/Sedation: Contact MRI Department for instructions</li> </ul>
<b>Ultrasound</b>	<p><b>Abdomen</b></p> <ul style="list-style-type: none"> <li>• Nothing to eat or drink 8 hours prior to exam</li> </ul> <p><b>OB, Pelvis or Renal</b></p> <ul style="list-style-type: none"> <li>• Start by emptying bladder 2 hours before appointment, then drink 32 ounces of water, finish 1 hour before appointment</li> <li>• Do not empty your bladder before your exam</li> </ul>
<b>Bone Densitometry</b>	<ul style="list-style-type: none"> <li>• No multi-vitamins or dietary supplements, including calcium, day of exam</li> </ul>
<b>Nuclear Medicine</b>	<ul style="list-style-type: none"> <li>• Nothing to eat or drink 8 hours prior to exam for: <ul style="list-style-type: none"> <li>– Myocardial perfusion</li> <li>– Thyroid uptake and scan</li> <li>– PET/CT</li> <li>– Gastric emptying</li> <li>– HIDA scan</li> </ul> </li> <li>• HIDA scan: No opiates or narcotics 6 hours prior to exam</li> <li>• Myocardial Perfusion: No caffeine 12 hours prior to exam</li> </ul>

*Note: Legacy Imaging does not provide childcare. Please make appropriate arrangements.*

**Locations**

**Legacy Emanuel Medical Center**

2801 N. Gantenbein Ave., Portland, OR 97227

**Legacy Good Samaritan Medical Center**

1015 N.W. 22nd Ave., Portland, OR 97210

**Legacy Meridian Park Medical Center**

19300 S.W. 65th Ave., Tualatin, OR 97062

**Legacy Meridian Park Medical Center**

Medical Plaza Office Building 2, Suite 165  
19260 S.W. 65th Ave., Tualatin, OR 97062

**Legacy Mount Hood Medical Center**

24800 S.E. Stark St., Gresham, OR 97030

**Legacy Mount Hood Medical Center**

Medical Office Building 3, Suite 100  
24988 S.E. Stark St., Gresham, OR 97030

**Legacy Salmon Creek Medical Center**

2211 N.E. 139th St., Vancouver, WA 98686

**Legacy Salmon Creek Medical Center**

Medical Office Building, Suite 150  
2101 NE 139th St., Vancouver, WA 98686

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