General Imaging Order Form

TODAY'S DATE: ______________________

REPORTING INSTRUCTIONS	
ROUTINE	STAT
STAT CALL REPORT – DIRECT LINE: ___________	
AFTER HOURS PHONE: ______________________	
PT TO GO	PT TO WAIT

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: scheduling.oregonimaging.com

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 the modality and write in the exam description.
X-Ray Fluoro/Diagnostics MRI MRA CT CTA US Exam Description: ______________________

X-RAY No appointment necessary

Skull
Sinus 1V 3View
Facial Bones
Chest 1 View (Positive PPD)
Chest 2 Views
Ribs w/PA Chest L R
Ribs w/ PA & 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 with 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) 334-7576

MRI

Contrast Choice
At Radiologist 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 Discretion
WO W W/WO
Brain
Maxillofacial
Sinus-Limited
Sinus-Complete
Neck Soft Tissue
Chest
Abdomen (Specific Organ) ________________
Abdomen/Pelvis
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

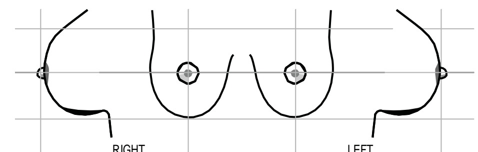
CTA-Brain
CTA-Neck
CTA-Chest
CTA-Chest for PE
CTA-Renal
CTA-Abdomen with Pelvis
CTA-Abdomen with Runoff

ULTRASOUND / DOPPLER

Thyroid
Carotid Doppler
AAA Doppler (Symptomatic) AAA
Screening (Asymptomatic)
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 L R
Ultrasound Breast L R
Breast Biopsy L R
Choose One:
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