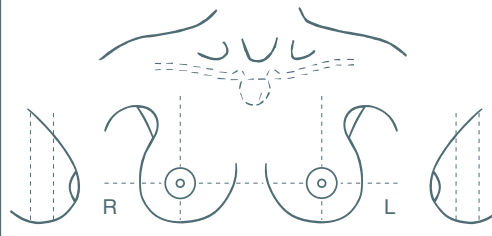


**SCHEDULE APPOINTMENT AT: (541) 382-9383**  
**Please Fax This Order To: (541) 382-6635**

This facsimile transmission contains confidential information to the sender which is protected by the physician - patient privilege. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking action of any kind in reliance to the information contained is strictly prohibited. If you received this transmission in error, please notify the sender by phone immediately to arrange for return of documents.

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Referring Physician \_\_\_\_\_  
 Appointment Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Appointment Time \_\_\_\_\_ am / pm (circle one) Patient has return visit on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Clinical Hx / Note to Radiologist / Tech: \_\_\_\_\_

Physician's Signature (required) **X**

X-RAY		ULTRASOUND
<p><b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b></p> <p><b>ABDOMEN</b></p> <input type="checkbox"/> Abdomen 1V (KUB) <input type="checkbox"/> Abdomen 2V <input type="checkbox"/> Abdomen 3V (W/Decubs) <input type="checkbox"/> Abdomen 2V W/PA Chest <p><b>G.I. TRACT</b></p> <input type="checkbox"/> Upper GI <input type="checkbox"/> Upper GI With Small Bowel <input type="checkbox"/> Esophagram <input type="checkbox"/> Small Bowel Follow Through <input type="checkbox"/> Barium Enema (Non Air Contrast) <input type="checkbox"/> Barium Enema (With Air Contrast) <input type="checkbox"/> T-Tube Cholangiogram <p><b>CHEST</b></p> <input type="checkbox"/> Chest 1V (PA) <input type="checkbox"/> Chest 2V (PA / Lateral) <input type="checkbox"/> Chest (Apical Lordotic & PA / Lateral) <input type="checkbox"/> Chest (PA / Lateral & Obliques) <input type="checkbox"/> Fluoroscopy, Sniff Test <input type="checkbox"/> Ribs Unilateral <input type="checkbox"/> Ribs Bilateral <input type="checkbox"/> Sternum <input type="checkbox"/> Ribs w / 1V Chest PA <p><b>HEAD &amp; NECK</b></p> <input type="checkbox"/> Eye (Detection Of Foreign Body) <input type="checkbox"/> Mandible Complete (PA & Oblique) <input type="checkbox"/> Facial 2V (PA / Lateral) <input type="checkbox"/> Facial Complete (PA / Waters / Lateral) <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Orbits (PA / Waters) <input type="checkbox"/> Waters View 1V <input type="checkbox"/> Sinus Series (PA / Waters / Lateral) <input type="checkbox"/> Skull 2V (AP / Lateral) <input type="checkbox"/> Skull Complete <input type="checkbox"/> Neck For Soft Tissue (AP / Lateral) <input type="checkbox"/> TMJ's <p><b>UPPER EXTREMITIES</b></p> <input type="checkbox"/> Scapula (AP / Lateral) <input type="checkbox"/> Clavicle (AP / Angle) <input type="checkbox"/> Shoulder (Int / Ext / Y) <input type="checkbox"/> AC Joint (With & Without Weights) <input type="checkbox"/> SC Joint (PA / Obliques) <input type="checkbox"/> Humerus (AP / Lateral) <input type="checkbox"/> Elbow 2V (AP / Lateral) <input type="checkbox"/> Elbow 3+ V (AP / Lateral & Oblique) <input type="checkbox"/> Forearm (AP / Lateral) <input type="checkbox"/> Wrist 2V (PA / Lateral) <input type="checkbox"/> Wrist 3+ V (PA / Lateral & Oblique) <input type="checkbox"/> Hand 2V (PA / Lateral) <input type="checkbox"/> Hand 3V (PA / Lateral & Oblique) <input type="checkbox"/> Finger (PA / Lateral & Oblique) Digit _____ <p><b>MYELOGRAMS</b></p> <input type="checkbox"/> Cervical With CT To Follow <input type="checkbox"/> Lumbosacral With CT To Follow <input type="checkbox"/> Thoracic With CT To Follow <p><b>ARTHROGRAM</b></p> <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Other: _____ <input type="checkbox"/> MR to follow <input type="checkbox"/> CT to follow	<p><b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b></p> <p><b>LOWER EXTREMITIES</b></p> <input type="checkbox"/> Unilateral Hip 2V <input type="checkbox"/> Bilateral Hip 2V (Including AP Pelvis) <input type="checkbox"/> Femur 2V (AP / Lateral) <input type="checkbox"/> Knees Bilateral AP Standing <input type="checkbox"/> Knee 2V (AP / Lateral) <input type="checkbox"/> Knee 3+ V <input type="checkbox"/> Knee 4+ V <input type="checkbox"/> Tibia & Fibula (AP / Lateral) <input type="checkbox"/> Ankle 2V (AP / Lateral) <input type="checkbox"/> Ankle 3+ V (AP / Lateral & Oblique) <input type="checkbox"/> Foot 2V (AP / Lateral) <input type="checkbox"/> Foot 3+ V (AP / Lateral & Oblique) <input type="checkbox"/> Calcaneus (Angle / Lateral) <input type="checkbox"/> Toe (AP / Lateral & Oblique) Digit _____ <p><b>THERAPUTIC INJECTIONS</b></p> <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Other: _____ <p><b>SPINE &amp; PELVIS</b></p> <input type="checkbox"/> Spine 1V <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar Which View: _____ <input type="checkbox"/> Cervical 2V / 3V (AP / Lateral) <input type="checkbox"/> Cervical Complete (AP / Lateral / OM / Obliques) <input type="checkbox"/> Thoracic / Swimmers (AP / Lateral / Swimmers) <input type="checkbox"/> Thoracic / Lumbar Junction (AP / Lateral) <input type="checkbox"/> Lumbar 2V / 3V (AP / Lateral) <input type="checkbox"/> Lumbar Complete (AP / Lateral / Obliques / L5-S1 Spots) <input type="checkbox"/> Pelvis 1V (AP) <input type="checkbox"/> SI Joints <input type="checkbox"/> Sacrum & Coccyx (AP / Lateral) <input type="checkbox"/> Scoliosis 1V <input type="checkbox"/> Lumbar Flex / Ext <p><b>MISCELLANEOUS</b></p> <input type="checkbox"/> Skeletal Survey <input type="checkbox"/> Bone Age <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Other: _____ <p><b>NUCLEAR MEDICINE</b></p> <p><b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b></p> <input type="checkbox"/> Bone Scan <input type="checkbox"/> Total <input type="checkbox"/> Limited <input type="checkbox"/> With Spect <input type="checkbox"/> 3 Phase <input type="checkbox"/> Gallbladder Ejection Fraction (GBEF) <input type="checkbox"/> Renal Function / Obstruction Scan (DTPA / MAG3) <input type="checkbox"/> Gastric Emptying Study <input type="checkbox"/> Myocardia Perfusion Imaging (MPI) <input type="checkbox"/> Lexiscan <input type="checkbox"/> Treadmill <input type="checkbox"/> Lung Scan (Vent / Perf) <input type="checkbox"/> Parathyroid Scan (Sestamibi) <input type="checkbox"/> Lymphoscintigraphy (Sentinel Node) <input type="checkbox"/> Other: _____ <p><b>DEXA</b></p> <input type="checkbox"/> Dexa (Axial) <input type="checkbox"/> Dexa with Vertebral Fracture Assessment	<p><b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b></p> <input type="checkbox"/> Abdomen (Complete) <input type="checkbox"/> Abdomen (Limited) <input type="checkbox"/> RUQ <input type="checkbox"/> LUQ <input type="checkbox"/> Aorta <input type="checkbox"/> Appendix <input type="checkbox"/> Renal <input type="checkbox"/> Obstetrical (1st Trimester) <input type="checkbox"/> Obstetrical (2nd - 3rd Trimester) <input type="checkbox"/> Obstetrical (Twins 1st Trimester) <input type="checkbox"/> Obstetrical (Twins 2nd - 3rd Trimester) <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Nuchal Translucency <input type="checkbox"/> Fetal Positioning Only <input type="checkbox"/> Pelvic Complete (TA / TV) <input type="checkbox"/> Sonohysterogram <input type="checkbox"/> Arterial Upper Extremities <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Arterial Lower Extremities <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Carotid <input type="checkbox"/> Venous Extremity Unilateral <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Venous Extremity Bilateral <input type="checkbox"/> Neo Natal Head <input type="checkbox"/> Fetal Hips <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Aspiration - Body Part: _____ <input type="checkbox"/> Extremity (Non Doppler) <input type="checkbox"/> Soft Tissue - Body Part: _____ <input type="checkbox"/> Thyroid <input type="checkbox"/> Thyroid Biopsy <input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> Groin <input type="checkbox"/> MSK - Body Part: _____ <input type="checkbox"/> Other: _____ <p><b>WOMEN'S IMAGING</b></p> <p><b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b></p> <input type="checkbox"/> Mammography Routine <input type="checkbox"/> Mammography Diagnostic <input type="checkbox"/> Mammography Unilateral <input type="checkbox"/> Breast Ultrasound To Compliment Mammo (unilat.) <input type="checkbox"/> Breast Ultrasound To Compliment Mammo (bilat.) <input type="checkbox"/> Breast Ultrasound (Unilat or Bilat W/O Mammogram) <input type="checkbox"/> Additional Views To Complete Mammogram <input type="checkbox"/> Needle Localization <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Ultrasound Guided Core Biopsy <input type="checkbox"/> Stereotactic Guided Core Biopsy <input type="checkbox"/> Ductogram <p><b>Please mark location below if pain or lump</b></p>  <p>_____ o'clock                  _____ cm from nipple</p>

Scheduling: 541-382-9383

Mainline: 541-382-6633

**PATIENT** - If your doctor's office has given you x-rays, please bring them with you to your appointment! See location map on back.  
If you have any questions about your exam or prep, please call our scheduling department at the above phone number.

**REFERRING OFFICE** - Please check the appropriate exam prep for your patient.

X-RAY	ULTRASOUND	NUCLEAR MEDICINE (cont.)
<p><input type="checkbox"/> <b>UPPER GI and/or ESOPHAGRAM and/or SBFT</b></p> <ol style="list-style-type: none"> <li>MORNING APPOINTMENT: DO NOT eat or drink anything after midnight the night before your exam. You may chew antacid tablets if desired, up to 2 hours before exam. Don't chew gum. DO NOT eat breakfast.</li> <li>AFTERNOON APPOINTMENT: You may eat a light liquid breakfast before 8:00 am. No food or fluids after 8:00 am. Don't chew gum.</li> <li>Allow approximately 45 minutes for your exam.</li> <li>If you are also having a small bowel exam - this combination can take as long as 4 hours.</li> </ol> <p><input type="checkbox"/> <b>BARIUM ENEMA</b></p> <ol style="list-style-type: none"> <li>This exam requires thorough emptying of the intestinal tract before the x-rays are taken.</li> <li>Please obtain a pre-packaged Evac-Q-Kwik laxative prep kit from our office.</li> <li>Carefully follow the <b>TWO DAY</b> prep instructions found inside the box.</li> <li>Allow approximately 1 hour for your exam.</li> </ol> <p><input type="checkbox"/> <b>INTRAVENOUS PYELOGRAM</b></p> <ol style="list-style-type: none"> <li>Pick up 3 Dulcolax (Bisodolyl) tablets from our office.</li> <li>The day before your exam, eat a light dinner.</li> <li>Take the 3 Dulcolax tablets at 6:00 pm. Do not take within 1 hour of antacids or milk. Swallow whole. Expect abdominal cramping, pain and diarrhea from this laxative preparation.</li> <li>Drink extra fluids.</li> <li>After each bowel movement, drink at least one-half glass of water, tea or broth.</li> <li>If your exam is scheduled in the MORNING, do not eat or drink anything until after your exam.</li> <li>If your exam is scheduled in the AFTERNOON you may have a light breakfast of toast and coffee, tea or juice. After breakfast, do not eat or drink anything until after your exam.</li> <li>Allow approximately 1 hour for your exam.</li> </ol>	<p><input type="checkbox"/> <b>PELVIS or OB</b></p> <p>Your bladder must be full to obtain a thorough exam. Drink 16 ounces of water approximately 1 hour before your appointment time and <b>DO NOT</b> empty your bladder. Allow approximately 1 hour for your exam.</p> <p><input type="checkbox"/> <b>UPPER ABDOMEN and GALLBLADDER</b></p> <p>Nothing to eat or drink for at least 10 hours before your exam. Allow approximately 1 hour for your exam.</p> <p><input type="checkbox"/> <b>RENAL / KIDNEY</b></p> <p>Your bladder must be full to obtain a thorough exam. Drink 32 ounces of water approximately 1 hour before your appointment time and <b>DO NOT</b> empty your bladder. Allow approximately 1 hour for your exam.</p> <p><input type="checkbox"/> <b>ARTERIAL LEGS</b></p> <p>Nothing to eat or drink for at least 4 hours before your exam. Allow approximately 90 minutes for your exam.</p> <p><input type="checkbox"/> <b>US or STEREOTACTIC BREAST CORE BIOPSY</b></p> <p>Please do not take any aspirin or blood thinners for 10 days prior to your appointment. Allow approximately 1 hour for your exam. Plan to take it easy the day of and the day after your biopsy.</p> <p><input type="checkbox"/> <b>ALL OTHER ULTRASOUND EXAMS</b></p> <p>There is no preparation. Allow approximately 1 hour for your exam.</p>	<p><input type="checkbox"/> <b>RENAL FUNCTION / OBSTRUCTION SCAN (DTPA/MAG3)</b></p> <ol style="list-style-type: none"> <li>Well hydrated, no coffee.</li> <li>Allow approximately 1 hour for your scan.</li> </ol> <p><input type="checkbox"/> <b>GASTRIC EMPTYING STUDY</b></p> <ol style="list-style-type: none"> <li>Nothing to eat or drink after midnight.</li> <li>DO NOT take any of the following medications for 3 days prior to your exam: <ul style="list-style-type: none"> <li>Narcotic Analgesics      Antidepressants</li> <li>Anticholinergics        Calcium Channel Blockers</li> <li>Octreotide</li> <li>Antacids containing Aluminum</li> </ul> </li> <li>Allow approximately 4 hours for your scan.</li> </ol> <p><input type="checkbox"/> <b>LUNG SCAN (Vent/Perf)</b></p> <ol style="list-style-type: none"> <li>No prep.</li> <li>Allow approximately 1.5 hours for your scan.</li> </ol> <p><input type="checkbox"/> <b>PARATHYROID SCAN (Sestamibi)</b></p> <ol style="list-style-type: none"> <li>No caffeine 4 hours prior.</li> <li>Allow approximately 3 hours for your scan.</li> </ol> <p><input type="checkbox"/> <b>LYMPHOSCINTIGRAPHY (Sentinel Node)</b></p> <ol style="list-style-type: none"> <li>No prep, follow surgical prep.</li> <li>Allow 20 minutes for injection and 2 hours for scan.</li> </ol> <p><input type="checkbox"/> <b>CARDIAC SCANS</b></p> <ol style="list-style-type: none"> <li>Myocardial Perfusion Imaging (MPI) - to assess myocardial blood perfusion and function under rest and stress. <ul style="list-style-type: none"> <li>a. No caffeine 24 hours prior to exam.</li> <li>b. NPO 6 hour prior to exam.</li> <li>c. Beta blockers and calcium channel blockers should be discontinued at physician's discretion.</li> </ul> </li> </ol>
<p><input type="checkbox"/> <b>PEDIATRIC PATIENTS FOR UGI, BE or IVP</b></p> <p>Call our office for special instructions.</p> <p><input type="checkbox"/> <b>HYSTEOSALPINGOGRAM</b></p> <p>Take 800mg of ibuprofen 1 hour before your exam. Please ensure there is no chance you could be pregnant. Allow approximately 1 hour for your exam.</p> <p><input type="checkbox"/> <b>MAMMOGRAM</b></p> <ol style="list-style-type: none"> <li>Bathe or otherwise carefully cleanse your breasts and underarms before your exam. Be careful to remove all deodorant, perfume, powders or preparation of any sort in the underarm areas of your breasts.</li> <li>You will find it more convenient to wear a blouse with slacks or skirt, rather than a dress.</li> <li>If you have had a mammogram at another facility, please bring it with you or request that it be sent to us.</li> <li>Allow approximately 45 minutes for your exam.</li> </ol> <p><input type="checkbox"/> <b>ROUTINE X-RAY(S)</b></p> <p>There is no preparation for this exam. Allow approximately 45 minutes for your exam.</p>	<p style="text-align: center;"><b>NUCLEAR MEDICINE</b></p> <p><input type="checkbox"/> <b>BONE SCAN</b></p> <p>With SPECT      W/O SPECT</p> <ol style="list-style-type: none"> <li>Drink 2 - 3 glasses of water or juice before scheduled injection time. No caffeine.</li> <li>After injection, drink 2 - 3 additional glasses of fluids.</li> <li>Return 2 - 4 hours after injection time for scan. Meds OK.</li> <li>You may eat, drink and empty your bladder after inj.</li> <li>Allow approximately 30 - 60 minutes for your scan.</li> </ol> <p><input type="checkbox"/> <b>GALLBLADDER EJECTION FRACTION (GBEF)</b></p> <ol style="list-style-type: none"> <li>Eat a fatty snack 8:00 - 10:00 pm the night before your scan. Then nothing to eat or drink after midnight.</li> <li><b>DO NOT</b> take any of the following medications within 24 hours of your exam or any other narcotic pain meds: <ul style="list-style-type: none"> <li>Morphine      Darvon      Demerol</li> <li>Dilaudid      Percocet      Tylenol w/ Codeine</li> <li>Vicodin        All Codeine drugs</li> </ul> </li> <li>Allow approximately 2 hours for your scan.</li> </ol> <p><input type="checkbox"/> <b>HIDA SCAN (Biliary)</b></p> <ol style="list-style-type: none"> <li>Eat a fatty snack 8:00 - 10:00 pm the night before your scan. Then nothing to eat or drink after midnight.</li> <li><b>DO NOT</b> take any of the following medications within 24 hours of your exam or any other narcotic pain meds: <ul style="list-style-type: none"> <li>Morphine      Darvon      Demerol</li> <li>Dilaudid      Percocet      Tylenol w/ Codeine</li> <li>Vicodin        All Codeine drugs</li> </ul> </li> <li>Allow approximately 2 hours for your scan.</li> </ol>	<p><input type="checkbox"/> <b>NM CARDIAC ORDERING INSTRUCTIONS</b></p> <ol style="list-style-type: none"> <li>Lexiscan Stress - vasodilatory agent used for patients who cannot complete a treadmill test.</li> <li>Treadmill Stress - preferred method to "stress" patients.</li> </ol>