



1460 NE Medical Center Drive
Bend, Oregon 97701
541-382-6633 Main • 541-382-9383 Scheduling



SCHEDULE APPOINTMENT AT: (541) 382-9383

Please Fax This Order To: (541) 382-6635

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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**

(PLEASE MARK EXAM(S) & EXAM TYPES)		CT	(PLEASE MARK EXAM(S) & EXAM TYPES)	
BRAIN OR HEAD <input type="checkbox"/> COMPLETE <input type="checkbox"/> TEMP. BONE <input type="checkbox"/> ORBIT <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> Without & With IV Contrast <input type="checkbox"/> With IV Contrast		CERVICAL SPINE <input type="checkbox"/> LEVELS OF INTEREST: _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With Myelogram <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	ABDOMEN - PELVIC AREAS UPPER ABDOMEN (Diaphragm to Iliac Crest) <input type="checkbox"/> ABDOMEN & PELVIS <input type="checkbox"/> ABDOMEN ONLY <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Adrenal Mass <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> Renal Mass <input type="checkbox"/> Pancreatic Mass <input type="checkbox"/> Liver <input type="checkbox"/> CT Colonography <input type="checkbox"/> CT Enterography <input type="checkbox"/> CT Urinary Tract (Without IV Contrast) <input type="checkbox"/> CT Urogram Without & With IV Contrast <input type="checkbox"/> CT Appendix PELVIS (Iliac Crest through Symphysis) <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without IV Contrast	
MAXILLOFACIAL <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without & With IV Contrast		THORACIC SPINE <input type="checkbox"/> LEVELS OF INTEREST: _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With Myelogram <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	<input type="checkbox"/> CT Colonography <input type="checkbox"/> CT Enterography <input type="checkbox"/> CT Urinary Tract (Without IV Contrast) <input type="checkbox"/> CT Urogram Without & With IV Contrast <input type="checkbox"/> CT Appendix PELVIS (Iliac Crest through Symphysis) <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without IV Contrast	
NASAL SINUSES <input type="checkbox"/> Landmarx Medtronic Sinus <input type="checkbox"/> Complete, Axial & Coronal		LUMBAR SPINE <input type="checkbox"/> LEVELS OF INTEREST: _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With Myelogram <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	UPPER EXTREMITY <input type="checkbox"/> Without IV Contrast Body Part: _____ <input type="checkbox"/> With IV Contrast <input type="checkbox"/> 3D Reconstructions <input type="checkbox"/> Joint Injected (Post Arthrogram): _____	
SOFT TISSUE NECK <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without & With IV Contrast		CT. ANGIOGRAPHY <input type="checkbox"/> Angio Abdomen (AAA, SMA, Renal, etc) <input type="checkbox"/> Angio Abdomen Aorta & Runoff <input type="checkbox"/> Angio Chest (TAA) <input type="checkbox"/> Angio Head (Circle Of Willis etc) <input type="checkbox"/> Angio Neck (Carotid) <input type="checkbox"/> Angio Pelvis <input type="checkbox"/> Angio Abdomen Pelvis <input type="checkbox"/> Angio Lower Extremity <input type="checkbox"/> Angio Upper Extremity <input type="checkbox"/> Angio Chest / Abdomen / Pelvis & Runoff	LOWER EXTREMITY <input type="checkbox"/> Without IV Contrast Body Part: _____ <input type="checkbox"/> With IV Contrast <input type="checkbox"/> 3D Reconstructions <input type="checkbox"/> Joint Injected (Post Arthrogram): _____	
CHEST - THORAX <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without & With IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> High Resolution / Interstitial Disease <input type="checkbox"/> Heart Calcium Scoring <input type="checkbox"/> Screening for Pulmonary Nodule <input type="checkbox"/> Pulmonary Arteries <input type="checkbox"/> Other:		MRI / MRA		
BRAIN OR HEAD <input type="checkbox"/> IAC <input type="checkbox"/> ORBIT <input type="checkbox"/> CRANIAL NERVES <input type="checkbox"/> P. FOSSA <input type="checkbox"/> PITUITARY <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> TMJ <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast <input type="checkbox"/> Spectroscopy <input type="checkbox"/> Stealth Protocol <input type="checkbox"/> Brain With Head / Neck Angio (stroke protocol) <input type="checkbox"/> Angio Head Only Without Contrast <input type="checkbox"/> Angio Neck Only Without Contrast <input type="checkbox"/> Angio Neck Only With and Without Contrast		M.S. WORKUP <input type="checkbox"/> Brain - Cervical - Thoracic (Complete With Contrast) <input type="checkbox"/> Brain - Cervical - Thoracic (Complete Without Contrast) <input type="checkbox"/> Limited to: _____	ANGIO - MISCELLANEOUS (cont.) <input type="checkbox"/> Other: _____	
SOFT TISSUE NECK <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast		BRACHIAL PLEXUS <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast	ABDOMEN - PELVIC AREAS <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast <input type="checkbox"/> MRCP <input type="checkbox"/> PELVIS <input type="checkbox"/> PROSTATE <input type="checkbox"/> UTERUS <input type="checkbox"/> LUMBOSACRAL PLEXUS <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast	
SPINE <input type="checkbox"/> CERVICAL <input type="checkbox"/> THORACIC <input type="checkbox"/> LUMBAR <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast		UPPER EXTREMITY <input type="checkbox"/> SHOULDER <input type="checkbox"/> ELBOW <input type="checkbox"/> WRIST <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILATERAL <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> Include Joint Injection Under Fluoroscopy <input type="checkbox"/> Soft Tissue: _____	CHEST <input type="checkbox"/> MEDIASTINUM <input type="checkbox"/> Without Contrast <input type="checkbox"/> Without & With Contrast	
BREAST <input type="checkbox"/> Silicone Implant Rupture <input type="checkbox"/> Breast Bilat Without & With		LOWER EXTREMITY <input type="checkbox"/> HIP <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILATERAL <input type="checkbox"/> Include Joint Injection Under Fluoroscopy <input type="checkbox"/> Soft Tissue: _____	CARDIAC <input type="checkbox"/> Cardiac Without Contrast <input type="checkbox"/> Cardiac Without & With Contrast <input type="checkbox"/> Cardiac Viability	
		ANGIO - MISCELLANEOUS <input type="checkbox"/> Angio - Arch / Carotids With Contrast <input type="checkbox"/> Angio - Chest Without and With Contrast <input type="checkbox"/> Angio - Abdomen With Renal Arteries <input type="checkbox"/> Angio - Abdomen With Runoffs		



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Patient Name _____ DOB ____/____/____ Referring Physician _____
 Appointment Date ____/____/____ Appointment Time _____ am / pm (circle one) Patient has return visit on ____/____/____

PATIENT - If your doctor's office has given you x-rays, please bring them with you to your appointment!
See location map on back

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

MRI SCANS - IMPORTANT INFORMATION

There is no preparation for most MRI scans unless you are claustrophobic, in which case your provider will need to prescribe medication for claustrophobia. If you have been issued medication for claustrophobia, remember to arrange for someone to drive you to and from your appointment. If you are scheduled for an MRCP study please have nothing to eat or drink for four hours prior to your exam. If you are pregnant, weigh over 300 pounds, have a pacemaker, aneurysm clip, vascular clip, pumps, stimulators, internal hearing aid, middle ear implant, filters or stents, electronic, mechanical or magnetic implant, have had any injury by metal, shrapnel, or bullet please call our office and ask to speak to an MRI tech. For pediatric patients - call our office for special instructions.

You will be asked to thoroughly complete our MRI pre-screening form and change into a gown before entering the exam room. You will not be able to bring any valuables (watch, wallet, credit cards, etc.) into the scan room. After you enter the exam room, the radiographer will position you on a special table. The area to be scanned will be moved into the machine. You will hear some knocking noise during your scan. It is important that you hold very still during your exam. The radiographer will control the scanner and monitor the progress of the exam from an adjacent room where she/he is able to see and hear you.

It is important to remember that every patient and exam is different. Consequently some scans will take longer or be more involved than others. Allow anywhere from 1 to 2 hours for completion of your scan. A radiologist will interpret your scan and send a report to your physician within 48 hours. Please contact our office and ask to speak with an MRI tech if you have any questions regarding your scan.

CT SCANS - IMPORTANT INFORMATION

After you enter the scan room the radiographer will position you on a special table. The area to be scanned will be moved into the ring, which contains an x-ray tube and computer receptors. The radiographer will control the scanner and monitor the progress of the exam from an adjacent room where she/he is able to see and hear you.

Frequently it is necessary to use an IV medication called contrast to highlight certain structures. This medicine will be given through a vein in your arm. During the injection you may feel warm and flushed and have a metallic taste in your mouth. These are normal side effects, which only last for a few minutes. True allergic reactions are rare but can occur with this material.

It is important to remember that every patient and exam is different. Consequently some scans will take longer or be more involved than others. A radiologist will interpret your scan and send a report to your physician within 48 hours. Please contact our office and ask to speak with a CT radiographer if you have any questions regarding your scan or prep instructions. For pediatric patients - call our office for special instructions.

CT SCAN of the SINUS, EXTREMITY, HEART or CT URINARY TRACT

1. There is no preparation for these exams.
2. Allow approximately 40 minutes for your exam.

CT SCAN of the HEAD, CHEST or NECK; HEAD or CHEST WITHOUT CONTRAST ONLY - NO PREP

1. Nothing to eat for 4 hours prior to your exam. Drink water ONLY prior to your exam.
2. You may take your normal medications.
3. If you are allergic to radiologic contrast media, call our office at least the day before your exam for special instructions.
4. Allow approximately 1 hour for your scan.

CT ANGIO

1. Nothing to eat for 4 hours prior to your exam. Drink water ONLY prior to your exam.
2. You may take your normal medications.
3. If you are allergic to radiologic contrast media, call our office at least the day before your exam for special instructions
4. For a CT angio of your abdominal aorta - drink 64 oz of water two hours before your appointment time.
5. Allow approximately 1 hour for your scan.

CT COLONOGRAPHY

1. Pick-up a Prep Kit from CORA.
2. Follow the **TWO DAY** prep instructions found inside the box.
3. Allow approximately 1 hour for your scan.

CT SPINE

1. There is no preparation for a routine spine CT.
2. Allow approximately 1 hour for a routine spine scan.
3. If you are scheduled for a myelogram with a CT to follow - ask your physician for a special instruction sheet. You may also pick this sheet up at our office.

CT SCAN of the ABDOMEN and/or PELVIS

1. Pick up oral prep at Central Oregon Radiology.
2. Mix bottle of prep with 32oz of water.
3. Drink 16oz 2 HOURS PRIOR to your exam.
4. Drink 16oz 1 HOUR PRIOR to your exam.
5. Do not eat for 4 hours prior to your exam with the exception of medications already prescribed by your physician. Drink water ONLY prior to your exam.
6. If you are diabetic continue your usual diet along with the oral prep at the appropriate times.
7. If you have previously had a reaction to x-ray contrast call our office prior to your appointment time.
8. Inform the radiographer if you have asthma, diabetes, heart or renal problems or could possibly be pregnant.
9. You may experience some diarrhea with this oral prep.
10. Allow approximately 1 hour for your scan.