



1693 SW Chandler  
Suite 260  
Bend, OR 97702  
(541) 318-6800

**SCHEDULING APPOINTMENT FOR:**  
Mammo, Ultrasound, X-ray Call: (541) 382-9383  
CT Call: (541) 312-8003

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.

**After Appointment Is Scheduled Please Fax This Order To: 382-6635**

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	X-RAY (cont.)	X-RAY (cont.)
<b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b>	<b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b>	<b>PLEASE MARK EXAM(S) &amp; EXAM TYPES</b>
<b>ABDOMEN</b>	<b>UPPER EXTREMITIES (cont.)</b>	<b>MISCELLANEOUS</b>
<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	<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"/> Fingers (PA Hand / Lateral & Oblique)	<input type="checkbox"/> Skeletal Survey <input type="checkbox"/> Bone Age (PA - Bilateral Hands / Wrists) <input type="checkbox"/> Scanogram (AP / Hips - Knees - Ankles) <input type="checkbox"/> Other: _____
<b>CHEST</b>	<b>LOWER EXTREMITIES</b>	<b>BREAST IMAGING</b>
<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"/> Ribs Unilateral <input type="checkbox"/> Ribs Bilateral <input type="checkbox"/> Sternum	<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 (AP / Lateral & Oblique) <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"/> Toes (AP Foot / Lateral & Oblique)	<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"/> Other: _____
<b>HEAD &amp; NECK</b>	<b>SPINE &amp; PELVIS</b>	<b>ULTRASOUND</b>
<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"/> Sella Turcica (Cone Down) <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 <input type="checkbox"/> Mastoids	<input type="checkbox"/> Spine 1V <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar Which View: _____ <input type="checkbox"/> Cervical 2V (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 (AP / Lateral) <input type="checkbox"/> Lumbar Minimum 4V (Bi Plane Bending Only) <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"/> Abdomen (Complete) <input type="checkbox"/> AAA <input type="checkbox"/> Kidneys <input type="checkbox"/> Abdomen (Limited) <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Arterial Upper Extremities <input type="checkbox"/> Arterial Lower Extremities <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"/> Extremity (Non Doppler) <input type="checkbox"/> Neo Natal Head <input type="checkbox"/> Pelvic <input type="checkbox"/> Obstetrical <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Obstetrical (Twins 1st Trimester) <input type="checkbox"/> Obstetrical (Twins 2nd - 3rd Trimester) <input type="checkbox"/> Fetal Positioning Only <input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> Soft Tissue (Head / Neck) <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____
<b>UPPER EXTREMITIES</b>		
<input type="checkbox"/> Scapula (AP / Lateral) <input type="checkbox"/> Clavicle (AP / Angle) <input type="checkbox"/> Shoulder (Int / Ext) <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)		
<b>PLEASE MARK EXAM(S) &amp; EXAM TYPE(S)</b>	<b>CT</b>	<b>PLEASE MARK EXAM(S) &amp; EXAM TYPE(S)</b>
<b>BRAIN OR HEAD</b>	<b>CERVICAL SPINE</b>	<b>ABDOMEN - PELVIC AREAS</b>
<input type="checkbox"/> COMPLETE <input type="checkbox"/> P. FOSSA <input type="checkbox"/> TEMP. BONE <input type="checkbox"/> ORBIT <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With & Without IV Contrast <input type="checkbox"/> With IV Contrast	<b>LEVELS OF INTEREST:</b> _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	<b>UPPER ABDOMEN (Diaphragm to Iliac Crest)</b> <input type="checkbox"/> ABDOMEN & PELVIC <input type="checkbox"/> ABDOMEN ONLY <input type="checkbox"/> With IV Contrast <input type="checkbox"/> With & Without IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> TRI Phase Liver <input type="checkbox"/> CT Colonoscopy (Entire Colon) <input type="checkbox"/> CT IVP (Kidneys Through Bladder) <input type="checkbox"/> CT Appendix
<b>MAXILLOFACIAL</b>	<b>THORACIC SPINE</b>	<b>PELVIC (Iliac Crest through Symphysis)</b>
<input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> With & Without IV Contrast	<b>LEVELS OF INTEREST:</b> _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	<input type="checkbox"/> PELVIC & ABDOMEN <input type="checkbox"/> PELVIC ONLY <input type="checkbox"/> With IV Contrast <input type="checkbox"/> With & Without IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With Pubic Arch Study
<b>NASAL SINUSES</b>	<b>LUMBAR SPINE</b>	<b>UPPER EXTREMITY</b>
<input type="checkbox"/> Limited <input type="checkbox"/> Complete, Axial & Coronal	<b>LEVELS OF INTEREST:</b> _____ <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Stealth	<input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> 3D Reconstructions
<b>SOFT TISSUE NECK</b>	<b>CT. ANGIOGRAPHY</b>	<b>LOWER EXTREMITY</b>
<input type="checkbox"/> With IV Contrast <input type="checkbox"/> With & Without IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> High Resolution <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Screening for Pulmonary Nodule <input type="checkbox"/> Limited <input type="checkbox"/> Other: _____	<input type="checkbox"/> Angio Abdomen (AAA, SMA, Renal, etc) <input type="checkbox"/> Angio 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 Lower Extremity <input type="checkbox"/> Angio Upper Extremity	<input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With IV Contrast <input type="checkbox"/> 3D Reconstructions



**(In the Westside Medical Center - Upper Level)**

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  
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

**MAMMOGRAM**

1. 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.
2. You will find it more convenient to wear a blouse with slacks or a skirt, rather than a dress.
3. If you have had a mammogram at another facility please bring it with you or request that it be sent to us.
4. Allow approximately 45 minutes for your exam.

**ROUTINE X-RAY(s)**

There is no preparation for this exam. Allow approximately 45 minutes for your exam.

### ULTRASOUND

**PELVIS or OB**

Your bladder must be full to obtain a thorough exam. Drink 16 ounces of water approximately 1 hour before your appointment time and **DO NOT** empty your bladder. Allow approximately 1 hour for your exam.

**UPPER ABDOMEN and GALLBLADDER**

Nothing to eat or drink for at least 10 hours before your exam. Allow approximately 1 hour for your exam.

**RENAL / KIDNEY**

Your bladder must be full to obtain a thorough exam. Drink 16 ounces of water approximately 1 hour before your appointment time and **DO NOT** empty your bladder. Allow approximately 1 hour for your exam.

**ARTERIAL LEGS**

Do not eat or drink anything for 4 hours prior to your exam. Allow approximately 90 minutes for your exam.

**ALL OTHER ULTRASOUND EXAMS**

There is no preparation. Allow approximately 1 hour for your exam.

### 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 s/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 or CT IVP**

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

**CT SCAN of the HEAD, CHEST or NECK**

1. Nothing to eat or drink for 4 hours prior to your exam.
2. You may take your normal medicines with the exception of Glucophage (metformin) or Glucovance.
3. If you take Glucophage or Glucovance or 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 or drink for 4 hours prior to your exam.
2. You may take your normal medicines with the exception of Glucophage (metformin) or Glucovance.
3. If you take Glucophage or Glucovance or 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 1 gallon of water two hours before your appointment time.
5. Allow approximately 1 hour for your scan.

**CT COLONOSCOPY**

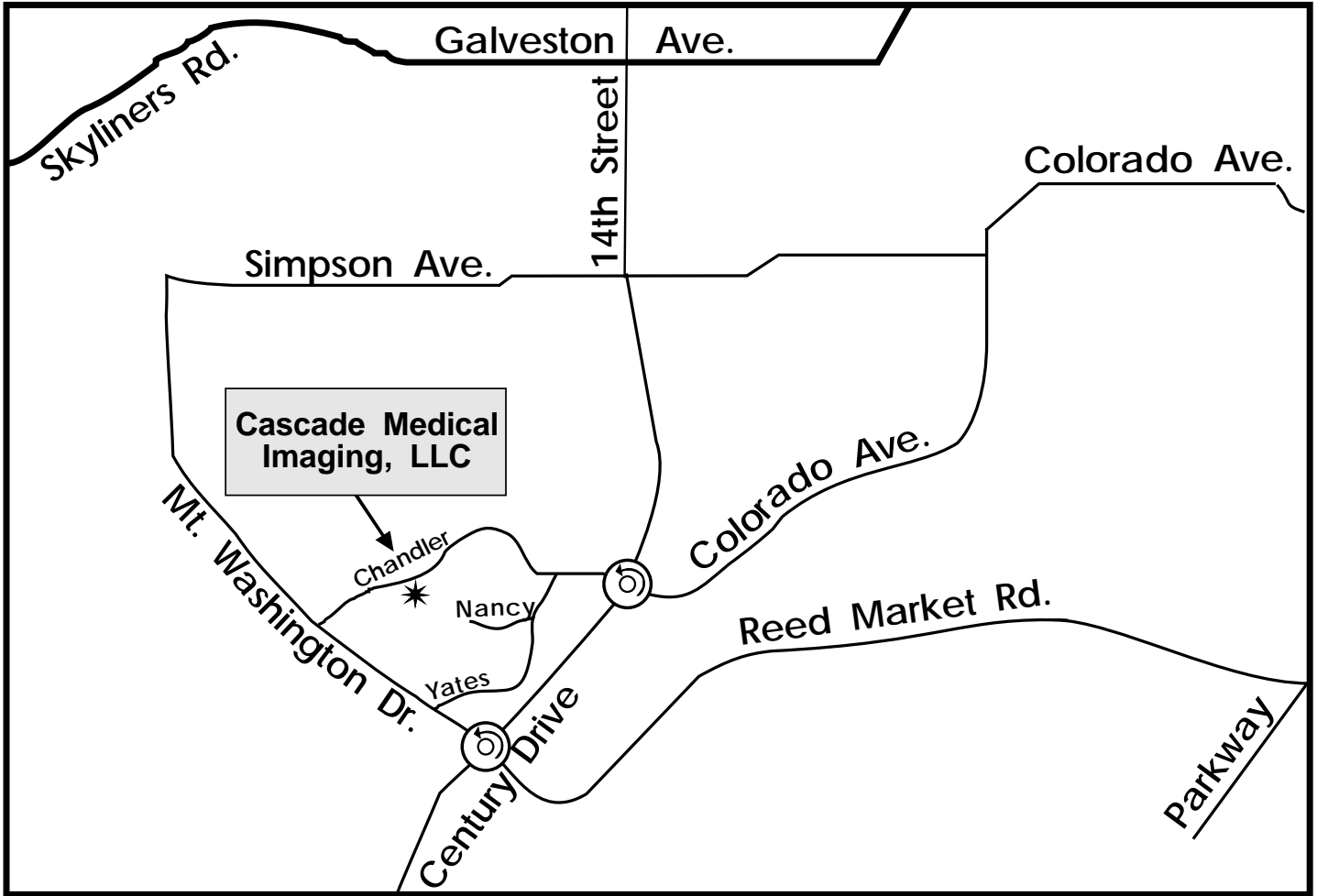
1. Pick-up an Evac-Q-Kwik kit from our office.
2. Follow the **TWO DAY** prep instructions found inside the box.
3. Allow approximately 1 hour for your scan.

**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 3 oral Hypaque doses at Cascade Medical Imaging.
2. Mix any one of the syringes of Hypaque with 12 ounces of clear juice (any type without pulp such as cranberry or apple) and drink at **8:00 pm THE EVENING BEFORE** your appointment.
3. Mix another syringe of Hypaque with 12 ounces of juice and drink **2 HOURS PRIOR** to your exam time.
4. Mix the last syringe of Hypaque with 12 ounces of juice and drink **1 HOUR PRIOR** to your exam time.
5. Do not eat or drink anything else for 4 hours prior to your exam with the exception of medications already prescribed by your physician.
6. If you are diabetic continue your usual diet along with the Hypaque at the appropriate times. **DIABETIC PATIENTS TAKING GLUCOPHAGE (metformin) or GLUCOVANCE** - contact our office for special instructions about taking your medication.
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.



1693 SW Chandler (In the Westside Medical Center - Upper Level)