

SCHEDULE APPOINTMENT AT: (541) 382-9383
After Appointment Is Scheduled Please Fax This Order To: 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 _____

X-RAY		
<p style="text-align: center;">PLEASE MARK EXAM(S) & EXAM TYPES</p> <p style="text-align: center;">ABDOMEN</p> <input type="checkbox"/> Abdomen 1V (KUB) <input type="checkbox"/> Abdomen 2V <input type="checkbox"/> Abdomen 3V (W/Decubus) <input type="checkbox"/> Abdomen 2V W/PA Chest <p style="text-align: center;">CHEST</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"/> Ribs Unilateral <input type="checkbox"/> Ribs Bilateral <input type="checkbox"/> Sternum <p style="text-align: center;">HEAD & NECK</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"/> 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 <p style="text-align: center;">ULTRASOUND</p> <input type="checkbox"/> Abdomen (Complete) <input type="checkbox"/> Abdomen (Limited) <input type="checkbox"/> AAA <input type="checkbox"/> Kidneys <input type="checkbox"/> Arterial Upper Extremities <input type="checkbox"/> RT <input type="checkbox"/> LT <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: _____	<p style="text-align: center;">PLEASE MARK EXAM(S) & EXAM TYPES</p> <p style="text-align: center;">UPPER EXTREMITIES</p> <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) <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) <p style="text-align: center;">LOWER EXTREMITIES</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 (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) <p style="text-align: center;">BREAST IMAGING</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"/> Ductogram <input type="checkbox"/> Other: _____	<p style="text-align: center;">PLEASE MARK EXAM(S) & EXAM TYPES</p> <p style="text-align: center;">SPINE & PELVIS</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 (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 <p style="text-align: center;">MISCELLANEOUS</p> <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: _____
MRI / MRA		
<p style="text-align: center;">(PLEASE MARK EXAM(S) & EXAM TYPES)</p> <p style="text-align: center;">BRAIN OR HEAD</p> <input type="checkbox"/> COMPLETE <input type="checkbox"/> P. FOSSA <input type="checkbox"/> IAC <input type="checkbox"/> ORBIT <input type="checkbox"/> FACIAL NERVES <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> TMJ <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> Include DWI (Diffusion Weighted Images) <input type="checkbox"/> Brain With Stealth <input type="checkbox"/> Stealth Protocol Only <input type="checkbox"/> Brain With Head / Neck Angio <input type="checkbox"/> Angio Head Only <input type="checkbox"/> Angio Neck Only <p style="text-align: center;">SOFT TISSUE NECK</p> <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast <p style="text-align: center;">SPINE</p> <input type="checkbox"/> CERVICAL <input type="checkbox"/> THORACIC <input type="checkbox"/> LUMBAR <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast	<p style="text-align: center;">M.S. WORKUP</p> <input type="checkbox"/> Brain - Cervical - Thoracic (Complete With Contrast) <input type="checkbox"/> Brain - Cervical - Thoracic (Complete Without Contrast) <input type="checkbox"/> Limited to: _____ <p style="text-align: center;">BRACHIAL PLEXUS</p> <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <p style="text-align: center;">CHEST</p> <input type="checkbox"/> MEDIASTINUM <input type="checkbox"/> CHEST WALL <input type="checkbox"/> Contrast / Radiologist Discretion <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast <p style="text-align: center;">UPPER EXTREMITY</p> <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: _____ <p style="text-align: center;">LOWER EXTREMITY</p> <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"/> Contrast / Radiologist Discretion <input type="checkbox"/> Include Joint Injection Under Fluoroscopy <input type="checkbox"/> Soft Tissue: _____	<p style="text-align: center;">(PLEASE MARK EXAM(S) & EXAM TYPES)</p> <p style="text-align: center;">ABDOMEN - PELVIC AREAS</p> <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> Liver With & Without Contrast <input type="checkbox"/> Pancreas With & Without Contrast <input type="checkbox"/> MRCP Liver <input type="checkbox"/> MRCP Pancreas With & Without Contrast <input type="checkbox"/> Renal With & Without Contrast <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"/> With & Without Contrast <p style="text-align: center;">ANGIO - MISCELLANEOUS</p> <input type="checkbox"/> Angio - Arch / Carotids With Contrast <input type="checkbox"/> Angio - Chest With or Without Contrast <input type="checkbox"/> Angio - Abdomen With Renal Arteries <input type="checkbox"/> Angio - Abdomen With Runoffs <input type="checkbox"/> Other: _____

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.

BREAST NEEDLE LOCALIZATION PROCEDURE

Your doctor has asked for our assistance in localizing the area in your breast, which needs to be biopsied. The procedure involves taking x-rays of your breast and placing a needle and wire exactly into the area in question.

THE PROCEDURE:

- You will be seated in a chair at the mammographic unit. Your breast will be placed on the plate and compressed with a special paddle, which has an opening and a grid pattern around the border. We will take an x-ray to see if the area to be localized is within the paddle opening.
- We will cleanse the necessary area of your breast with an antiseptic and the radiologist will administer a local anesthetic. S/he will insert a needle into your breast and we will take an x-ray to check the position of the needle. If the radiologist determines that the needle is in the correct position we will take another x-ray in a different position to confirm this. If the needle is not in the correct position it will be repositioned and new x-rays taken. We will continue in this manner until the needle is in the appropriate position.
- Once the needle is in the area to be biopsied the radiologist will thread a thin wire down the center of the needle into the breast. The needle will be removed and the wire will remain in place. A final set of three x-rays will be taken which you will take with you to surgery.
- We will place a bandage over the wire and ask that you not wear your bra. It would be most convenient for you to wear a blouse, which buttons up the front with slacks or a skirt. Even though the wire is anchored in place you still need to protect its position. We ask that you keep your shoulder and arm movement to a minimum.
- We will do our best to keep you comfortable during this procedure as it is absolutely imperative that you not change your position at all from the time we begin until we take our final x-rays. There is no way for us to predict how long this procedure will take. You should plan on being in our office from one to two hours.

We understand this is a very anxious time for you. We are here to assist your physician and to make this as easy as possible for you. If you have any questions before or during the procedure please do not hesitate to call (541) 923-4202 or ask us.

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.

US BREAST CORE BIOPSY

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.

ALL OTHER ULTRASOUND EXAMS

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

MRI SCANS - IMPORTANT INFORMATION

There is no preparation for most MRI scans unless you are claustrophobic, in which case you need to arrange for someone to drive you home after your scan. 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.

Michael J. Donley, M.D.
James E. Johnson, M.D.
Laurie A. Martin, M.D.

David A. Krieves, M.D.
Patrick B. Brown, M.D.
Steven D. Kjobech, M.D.

Ronald D. Hanson, M.D.
Jeffrey Drutman, M.D.
Dean J. Busby, M.D.

Thomas E. Jett, M.D.
Traci Clautice-Engle, M.D.
Thomas F. Koehler, M.D.

REDMOND LOCATION

