

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		
PLEASE MARK EXAM(S) & EXAM TYPES	PLEASE MARK EXAM(S) & EXAM TYPES	PLEASE MARK EXAM(S) & EXAM TYPES
ABDOMEN	UPPER EXTREMITIES	SPINE & PELVIS
<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"/> 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)	<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
G.I. TRACT	LOWER EXTREMITIES	MYELOGRAMS
<input type="checkbox"/> Upper GI <input type="checkbox"/> Upper GI With / Esophagram <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	<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"/> Cervical Spine <input type="checkbox"/> Cervical With CT To Follow <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Lumbosacral With CT To Follow <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Thoracic With CT To Follow
URINARY TRACT	JOINT INJECTIONS	MISCELLANEOUS
<input type="checkbox"/> I.V. Pyelogram	<input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder Arthrogram <input type="checkbox"/> Shoulder With CT To Follow <input type="checkbox"/> Shoulder With MRI To Follow <input type="checkbox"/> Elbow Arthrogram <input type="checkbox"/> Elbow With CT To Follow <input type="checkbox"/> Elbow With MRI To Follow <input type="checkbox"/> Wrist Arthrogram <input type="checkbox"/> Wrist With CT To Follow <input type="checkbox"/> Wrist With MRI To Follow <input type="checkbox"/> Knee Arthrogram <input type="checkbox"/> Knee With CT To Follow <input type="checkbox"/> Knee With MRI To Follow	<input type="checkbox"/> Fistula or Sinus Tract Study <input type="checkbox"/> Skeletal Survey <input type="checkbox"/> Short Fluoroscopy of _____ <input type="checkbox"/> Bone Age (PA - Bilateral Hands / Wrists) <input type="checkbox"/> Scanogram (AP / Hips - Knees - Ankles) <input type="checkbox"/> Venogram (Unilateral) <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Venogram (Bilateral) <input type="checkbox"/> Facet Injection - Level: _____ <input type="checkbox"/> Epidural Injection <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Hip Injection <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Tomo., Body Part: _____ <input type="checkbox"/> Other: _____
CHEST	ULTRASOUND (cont.)	NUCLEAR MEDICINE
<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"/> Chest Fluoroscopy <input type="checkbox"/> Ribs Unilateral <input type="checkbox"/> Ribs Bilateral <input type="checkbox"/> Sternum	PLEASE MARK EXAM(S) & EXAM TYPES	PLEASE MARK EXAM(S) & EXAM TYPES
HEAD & NECK	<input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> Soft Tissue (Head / Neck) <input type="checkbox"/> Thyroid <input type="checkbox"/> Thyroid Biopsy	<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 Cortical Scan (DMSA) <input type="checkbox"/> Renal Function / Obstruction Scan (DTPA / MAG3) <input type="checkbox"/> Renovascular Hypertension Scan <input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Gastric Emptying Study <input type="checkbox"/> Gallium Scan <input type="checkbox"/> Cardiac (MUGA) <input type="checkbox"/> Lung Scan (Vent / Perf) <input type="checkbox"/> Parathyroid Scan (Sestamibi) <input type="checkbox"/> Lymphoscintigraphy (Sentinel Node) <input type="checkbox"/> Other: _____
<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	PLEASE MARK EXAM(S) & EXAM TYPES	PLEASE MARK EXAM(S) & EXAM TYPES
ULTRASOUND	<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"/> Cyst Aspiration <input type="checkbox"/> Aspiration - Body Part: _____ <input type="checkbox"/> Neo Natal Head <input type="checkbox"/> Pelvic <input type="checkbox"/> Sonohysterogram <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"/> Other: _____	<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

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	ULTRASOUND	NUCLEAR MEDICINE (cont.)
<input type="checkbox"/> UPPER GI and/or ESOPHAGRAM and/or SBFT 1. 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. 2. 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. 3. Allow approximately 45 minutes for your exam. 4. If you are also having a small bowel exam - this combination can take as long as 4 hours. <input type="checkbox"/> BARIUM ENEMA 1. This exam requires thorough emptying of the intestinal tract before the x-rays are taken. 2. Please obtain a pre packaged Evac-Q-Kwik laxative prep kit from our office 3. Carefully follow the TWO DAY prep instructions found inside the box. 4. Allow approximately 1 hour for your exam. <input type="checkbox"/> INTRAVENOUS PYELOGRAM 1. Pick up 3 Dulcolax (Bisacodyl) tablets from our office. 2. The day before your exam, eat a light dinner. 3. 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. 4. Drink extra fluids. 5. After each bowel movement, drink at least one-half glass of water, tea or broth. 6. If your exam is scheduled in the MORNING, do not eat or drink anything until after your exam 7. 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. 8. Allow approximately 1 hour for your exam. <input type="checkbox"/> PEDIATRIC PATIENTS FOR UGI, BE or IVP Call our office for special instructions. <input type="checkbox"/> MYELOGRAM Ask your doctor or stop by our office for a special instruction sheet. <input type="checkbox"/> HYSTEOSALPINGOGRAM Take 800 mg of Ibuprofen 1 hour before your exam. Please ensure there is no chance you could be pregnant. Allow approximately 1 hour for your exam. <input type="checkbox"/> 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. <input type="checkbox"/> ROUTINE X-RAY(s) There is no preparation for this exam. Allow approximately 45 minutes for your exam.	<input type="checkbox"/> 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. <input type="checkbox"/> UPPER ABDOMEN and GALLBLADDER Nothing to eat or drink for at least 10 hours before your exam. Allow approximately 1 hour for your exam. <input type="checkbox"/> RENAL / KIDNEY Your bladder must be full to obtain a thorough exam. Drink 32 ounces of water approximately 1 hour before your appointment time and DO NOT empty your bladder. Allow approximately 1 hour for your exam. <input type="checkbox"/> ARTERIAL LEGS Do not eat or drink anything for 4 hours prior to your exam. Allow approximately 90 minutes for your exam. <input type="checkbox"/> US OR STEREOTACTIC 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. <input type="checkbox"/> SONOHYSTEROGRAM Take 800 mg of Ibuprofen 1 hour before your exam. You should not be on your menstrual period for this exam. Allow approximately 1 hour for your exam. <input type="checkbox"/> ALL OTHER ULTRASOUND EXAMS There is no preparation. Allow approximately 1 hour for your exam.	<input type="checkbox"/> Renal Cortical Scan (DMSA) 1. Drink 2-4 glasses of water (not coffee) before scheduled injection time. 2. Return 3 hours after injection time for scan. 3. Allow approximately one hour for scan. <input type="checkbox"/> Renal Function / Obstruction Scan (DTPA/MAG3) 1. Drink 2-4 glasses of water (not coffee) before scheduled injection time. 2. Allow approximately one hour for scan. <input type="checkbox"/> Renovascular Hypertension Scan (Captopril) 1. Drink 2-4 glasses of water (not coffee) before injection time. 2. Do not take any Ace Inhibitors for 2 days before scan and no Diuretics for 5 days before scan. 3. Do not eat anything for two hours prior to scan. 4. Allow approximately 2 hours for scan. 5. You may need to return 2 days later for additional imaging. <input type="checkbox"/> Gastroesophageal Reflux 1. Adult patient - nothing to eat or drink for 6 hours prior to scan. 2. Pediatric patient - skip one feeding and bring a bottle of breast milk or formula. Patients under the age of reason need to be hungry enough to eat under an unusual condition. 3. Sleep deprive a patient 4 years old and under. 4. Allow approximately 1.5 hours for scan. <input type="checkbox"/> Gastric Emptying Study 1. Nothing to eat or drink for a minimum of 6 hours prior to scan. 2. DO NOT take any of the following medications for 3 days prior to exam: Narcotic Analgesics Antidepressants Anticholinergics Calcium Channel Blockers Ocreotide Antacids containing aluminum 3. Allow approximately 3 hours for scan. <input type="checkbox"/> Gallium Scan 1. You will be scanned 24 hours after your injection time. 2. You may need to return for additional imaging 48 hours after injection time. 3. Allow approximately one hour for scan. <input type="checkbox"/> Cardiac MUGA 1. Nothing to eat or drink 4 hours prior to scan. 2. Allow approximately 1.5 hours for scan. <input type="checkbox"/> Lung Scan (Vent/Perf) 1. No prep 2. Allow approximately 1 hour for scan. <input type="checkbox"/> Parathyroid Scan (Sestamibi) 1. No Prep 2. Allow approximately 3 hours for scan. <input type="checkbox"/> Lymphoscintigraphy (Sentinel Node) 1. No Prep 2. Allow approximately 1 hour for scan.
	NUCLEAR MEDICINE	
	<input type="checkbox"/> Bone Scan <input type="checkbox"/> With SPECT <input type="checkbox"/> W/O SPECT 1. Drink 2-3 glasses of water / juice before scheduled injection time. 2. After injection drink 2-3 additional glasses of fluids. 3. Return 3 hours after injection time for scan. 4. You may eat, drink & empty your bladder. 5. Allow approximately one hour for scan. <input type="checkbox"/> Gallbladder Ejection Fraction (GBEF) 1. Eat a fatty snack @ 10:00 pm the night before your scan - then nothing to eat or drink after midnight. 2. Nothing to eat or drink for a minimum of 4 hours and a maximum of 24 hours prior to your exam. 3. DO NOT take any of the following medications within 24 hours of your exam: Morphine Darvon Demerol Dilaudid Percocet Tylenol w/Codeine Vicodin All Codeine drugs 4. Allow approximately two hours for scan. <input type="checkbox"/> HIDA Scan (Biliary) 1. Nothing to eat or drink for a minimum of 4 hours and a maximum of 24 hours prior to your exam. 2. DO NOT take any of the following medications within 24 hours of your exam: Morphine Darvon Demerol Dilaudid Percocet Tylenol w/Codeine Vicodin All Codeine drugs 3. Allow approximately two hours for scan.	

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

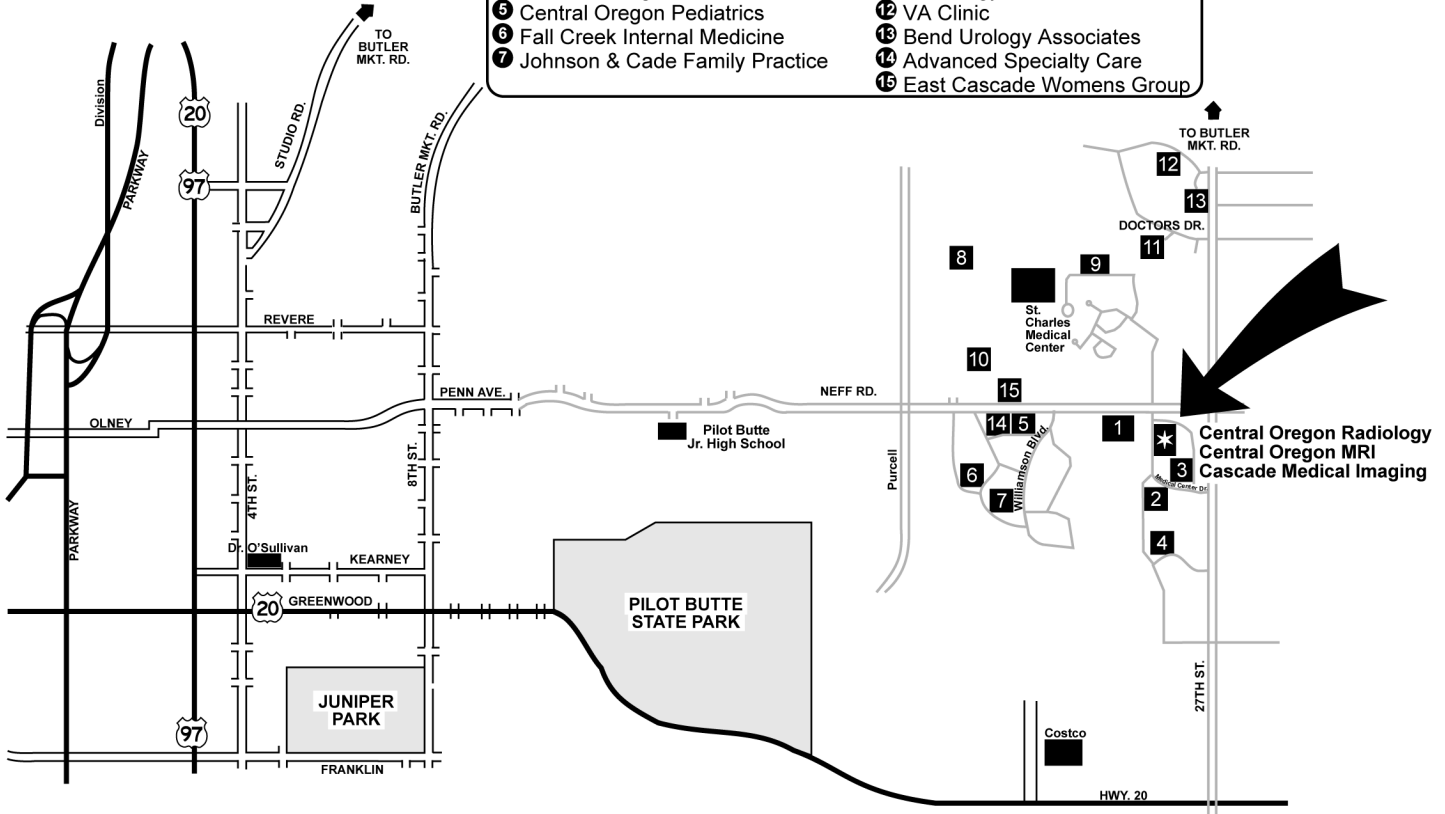
Patrick B. Brown, M.D.
Steven D. Kjobech, M.D.
Ronald D. Hanson, M.D.
Jeffrey Drutman, M.D.

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

Robert E. Hogan, M.D.
Stephen M. Shultz, M.D.
David R. Zulauf, M.D.
Steven J. Michel, M.D.

BEND LOCATION

- | | |
|-----------------------------------|------------------------------|
| 1 Bend Memorial Clinic | 8 The Center |
| 2 High Lakes Health East | 9 Pilot Butte Medical Center |
| 3 Desert Orthopedics | 10 Volunteers in Medicine |
| 4 Pinnacle Surgical Professionals | 11 Neurology of Bend |
| 5 Central Oregon Pediatrics | 12 VA Clinic |
| 6 Fall Creek Internal Medicine | 13 Bend Urology Associates |
| 7 Johnson & Cade Family Practice | 14 Advanced Specialty Care |
| | 15 East Cascade Womens Group |



REDMOND LOCATION

