Patient Referral

2925 Ryan Drive SE • Salem, Oregon 97301 • Phone: 503.399.1262 • Fax: 503.371.0777

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Patient Name: ______________________________ Date of Birth: __________

Appointment Date: ______________________________ Time: __________

Patient Phone#: __________________ Ordering Physician: __________________

Imaging Requested:

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Before your appointment, please complete the back of this form, and bring it with you for your appointment.

Please arrive 15 minutes before your scheduled time.

History and Tentative Diagnosis   Diagnosis Code: __________________

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Phone Results: ❑ Immediately   ❑ By (time) __________   ❑ Fax Results by (time) __________

Have Patient: ❑ Wait   ❑ Leave   ❑ Return with Films

Indicate patient preparation below.

Patient Preparation:

MRI — No preparation is necessary / Metal Precautions apply.

C.T. — If your C.T. involves the injection of contrast material, have clear liquids only for 4 hours prior to your exam. *Patients must weigh less than 330 lbs. due to table load limit.*

Ultrasound Attn. Clinician - Please check appropriate boxes below

Preparation Required, See Below

❑ **UPPER ABDOMEN:** (Includes Liver, Gall Bladder, Biliary Ducts, Pancreas, and Para-aortic Region) Nothing by mouth after midnight.

❑ **AORTA:** Nothing by mouth after midnight.

❑ **PELVIS:** (Uterus, Tubes, and Ovaries) 32 oz. of water finished 1/2 hour prior to exam. No voiding until exam is complete.

❑ **OBSTETRICAL:** 20 oz of water finished 1/2 hour prior to exam. No voiding until exam is complete.

❑ **If less than 18 weeks, patient may be rescheduled!**

No Preparation Required

- APPENDIX
- BREAST
- RENAL
- THYROID
- CAROTID
- TESTICULAR
- SHOULDER
- OTHER MUSCULOSKELETAL

Bone Densitometry (DEXA) Scans — On the day of your exam, do not take any calcium tablets or TUMS. Patient must weigh less than 300 lbs. due to table load limit.

X-Ray — No preparation needed.

Patient Information

Patient's Name: ______________________ Sex: ❑ M ❑ F

Mailing Address: ______________________ Apt.# __________

City: ______________ State: __________ Zip: __________

Phone (Home): ______________ Age: __________ Birthdate: __________

Phone (Work): ______________ S.S.# ______________

Primary Insurance Co. ______________________

Insured's Employer: ______________________

Group #: __________ ID #: ______________

Insured's Name/Guarantor: ______________________

Secondary Insurance Co. ______________________

Insured's Employer: ______________________

Group #: __________ ID #: ______________

Insured's Name/Guarantor: ______________________

On Job Claim: ❑ Y ❑ N Injury Date: ______________

Cause of Injury: ______________________

Date of Next Appointment with your Physician: ______________

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Salem Radiology Consultants to release from my medical record any information required by my insurance carrier or any person, company, or agency responsible for processing my claims for medical services.

FINANCIAL ARRANGEMENTS: I authorize payment directly to Salem Radiology Consultants of all insurance or health plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance or other agency, and for any co-pays, deductibles and / or coinsurance.

SIGNED: ______________________ **DATE:** __________

I authorize my medical images and reports to be released to:

Salem Radiology Consultants
2925 Ryan Dr. SE
Salem, OR 97301
Phone: 503-399-1262 / Fax: 503-763-7479

Please provide the name of the facility and location where you have had previous exams performed:

Doctor/Facility ______________ Facility Phone # ______________

City ______________ State/Zip ______________

Print your name ______________ Birthdate __________

Signature ______________ Todays Date __________

Any previous names you have used in the past ______________

Office use only:

SRC ID #: ______________ Type of films/images needed ______________

Before your appointment, please complete the patient information, and bring it with you for your appointment.

Please arrive 15 minutes before your scheduled time.

Our Location:
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Phone: 503.399.1262
Fax: 503.371.0777
www.salemradiology.com