

# 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History and Tentative Diagnosis \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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.**

- 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

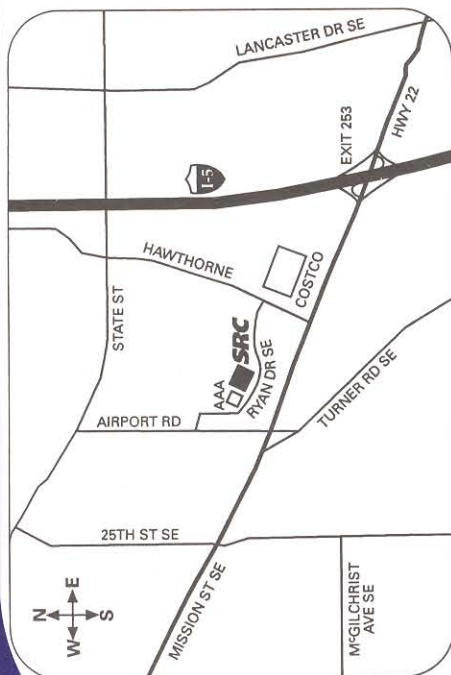
**Before your appointment, please complete the patient information, and bring it with you for your appointment.**

**Please arrive 15 minutes before your scheduled time.**

**Our Location:**

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

[www.salemradiology.com](http://www.salemradiology.com)



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 \_\_\_\_\_