Patient Referral

SRC Salem RADIOLOGY CONSULTANTS, P.C.

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

Patient Name: _____ Date of Birth: _____

Appointment Date: _____ Time: _____

Patient Phone#: _____ Ordering Physician: _____

Imaging Requested:

_____

_____

_____

_____

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: _____

_____

_____

_____

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.

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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: _____

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

Please arrive 15 minutes before your scheduled time.

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 # _____

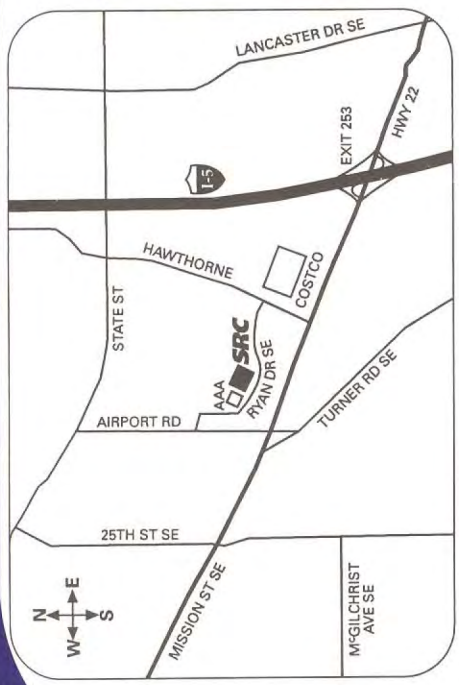
City _____ State/Zip _____

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 _____

Our Location:
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