



Rogue Regional Medical Center
5025 E. Barnett Rd., Medford, OR 97504

Appointment Date: _____

Appointment Time: _____

LAST NAME		FIRST NAME		SEX	DOB
DIAGNOSIS/ICD#/SYMPTOMS				PATIENT CONTACT NUMBER	
INSURANCE			PRE-AUTHORIZATION #		
PHYSICIAN FAX/CONTACT NUMBER			<input type="checkbox"/> STAT <input type="checkbox"/> FAX <input type="checkbox"/> PHONE		

ARRMC IMAGING SERVICES			SCHEDULING: 541-789-4322		FAX: 541-789-7170	
HEAD <input type="checkbox"/> Skull <input type="checkbox"/> Facial <input type="checkbox"/> Mandible <input type="checkbox"/> Waters <input type="checkbox"/> STLN <input type="checkbox"/> Z. Arch <input type="checkbox"/> TMJ's <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Orbits	EXTREMITIES R L Shoulder R L AC Joints R L Clavicle R L Scapula R L Humerus R L Elbow R L Forearm R L Wrist R L Hand R L Finger R L Hip R L Femur R L Knee R L Leg R L Ankle R L Foot R L Calcaneus R L Toe Other: _____	GENERAL US <input type="checkbox"/> Abdomen (GB UIt) (2)(7) <input type="checkbox"/> Renal (5) <input type="checkbox"/> Aorta (1) <input type="checkbox"/> Pelvis (5) <input type="checkbox"/> Pelvic/Transvag (5) <input type="checkbox"/> OB (5) <input type="checkbox"/> Thyroid (1) <input type="checkbox"/> Testicular (1) <input type="checkbox"/> Paracentesis (9) <input type="checkbox"/> Thoracentesis (9) <input type="checkbox"/> Other: _____	CT <input type="checkbox"/> Head (1) <input type="checkbox"/> Abdomen (3) <input type="checkbox"/> Chest (4) <input type="checkbox"/> Pelvis (3) <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> C-Spine (4) <input type="checkbox"/> T-Spine (4) <input type="checkbox"/> L-Spine (4) <input type="checkbox"/> Sinus <input type="checkbox"/> Sinus/Facial (4) <input type="checkbox"/> Complete Sinus <input type="checkbox"/> Orbit (4) <input type="checkbox"/> Cardiac Scoring <input type="checkbox"/> Other: _____ <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Con. <input type="checkbox"/> Contrast per Radiologist Special Instructions: _____	MRI <input type="checkbox"/> Brain (8) <input type="checkbox"/> Abdomen (8) <input type="checkbox"/> Pelvis (8) <input type="checkbox"/> C-Spine (8) <input type="checkbox"/> T-Spine (8) <input type="checkbox"/> L-Spine (8) <input type="checkbox"/> Lower Extremity R L <input type="checkbox"/> Upper Extremity R L <input type="checkbox"/> Other: _____ <input type="checkbox"/> Without Contrast <input type="checkbox"/> With and Without Contrast	NUCLEAR MEDICINE <input type="checkbox"/> Bone Scan <input type="checkbox"/> Whole Body (4) <input type="checkbox"/> Limited (4) <input type="checkbox"/> Bone 3 Phase (4) <input type="checkbox"/> Gastric Empty (4) <input type="checkbox"/> HIDA w/CCK (2) <input type="checkbox"/> MUGA <input type="checkbox"/> Thyroid (6)(2) <input type="checkbox"/> Scan & Uptake <input type="checkbox"/> Uptake only <input type="checkbox"/> Lung Scan (4) <input type="checkbox"/> Stress Test <input type="checkbox"/> Exercise <input type="checkbox"/> Lexi Scan Height: _____ Weight: _____ Other: _____	
SPINE <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> LS-Spine <input type="checkbox"/> Pelvis <input type="checkbox"/> Other: _____	GU TRACT <input type="checkbox"/> IVP (3) <input type="checkbox"/> VCUG (1) <input type="checkbox"/> Cystogram (1) GI TRACT <input type="checkbox"/> KUB <input type="checkbox"/> UGI (2) <input type="checkbox"/> Esophagegram (1) <input type="checkbox"/> SBFT (2) <input type="checkbox"/> B.E. (3) <input type="checkbox"/> 2 V. ABD	VASCULAR US Venous Doppler R L Leg Venous (1) R L Arm Venous (1) Arterial Doppler R L Leg (1) R L Arm (1) <input type="checkbox"/> Carotid (1) <input type="checkbox"/> Aorta & Renal (2) <input type="checkbox"/> Other: _____	ECHO <input type="checkbox"/> Adult Echocardiogram <input type="checkbox"/> Pediatric Echocardiogram <i>*Infants need to be tired and hungry</i> <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> Exercise Supine Bicycle <input type="checkbox"/> Dobutamine <input type="checkbox"/> TEE (Transesophageal Echo) <i>*NPO 6 hrs. prior to test</i>	<i>*Screening documentation will be completed by patient on arrival.</i>		

ARRMC CARDIAC STUDIES			SCHEDULING: 541-789-3145		FAX: 541-789-3147	
CARDIAC ULTRASOUND <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> Exercise Supine Bicycle (c) <input type="checkbox"/> Dobutamine	CARDIAC STRESS TEST <input type="checkbox"/> Treadmill	NUCLEAR MEDICINE <input type="checkbox"/> Nuclear Stress Test <input type="checkbox"/> Exercise (c) <input type="checkbox"/> Pharmacologic <input type="checkbox"/> LexiScan	Height: _____ Weight: _____	Patients scheduled for Cardiac Studies exams will report to the Cardiovascular Institute building, Department located on the 1 st floor, East side.		

ARRMC CARDIOPULMONARY		SCHEDULING: 541-789-5049		FAX: 541-789-5867	
PULMONARY DIAGNOSTICS <input type="checkbox"/> Full PFT-Spirometry, pre and post, DLCO, Lung volumes with airway resistance <input type="checkbox"/> Spirometry <input type="checkbox"/> Spirometry pre-and post-bronchodilator <input type="checkbox"/> Diffusion Capacity - DLCO <input type="checkbox"/> Methacoline challenge <input type="checkbox"/> Indirect calorimetry - metabolic study <input type="checkbox"/> Exercise induced asthma challenge <input type="checkbox"/> Maximum voluntary ventilation <input type="checkbox"/> Cardiopulmonary stress test with ABG's <input type="checkbox"/> Pre-Exercise <input type="checkbox"/> Peak-Exercise <input type="checkbox"/> Arterial blood gas with oxygen <input type="checkbox"/> LPM <input type="checkbox"/> Room Air <input type="checkbox"/> Oximetry - at rest or with exercise with oxygen <input type="checkbox"/> LPM <input type="checkbox"/> Room Air <input type="checkbox"/> Six Minute Walk <input type="checkbox"/> POCA-Preoperative cardiopulmonary assessment	<input type="checkbox"/> IOS <input type="checkbox"/> IOS-a and p Bronchodilator	CARDIOLOGY <input type="checkbox"/> Holter Monitor <input type="checkbox"/> 24 Hour <input type="checkbox"/> 48 hour <input type="checkbox"/> King of Hearts-Demand event monitor <input type="checkbox"/> Tilt Table <input type="checkbox"/> Baseline <input type="checkbox"/> With Isuprel <input type="checkbox"/> Electrocardiogram <input type="checkbox"/> Ambulatory B/P Monitoring <input type="checkbox"/> Cardiac exercise treadmill testing <input type="checkbox"/> External counter pulsation-ECP	ELECTRONEURODIAGNOSTICS <input type="checkbox"/> Auditory EP limited-AABR <input type="checkbox"/> Auditory EP comprehensive - BAER <input type="checkbox"/> Visual EP <input type="checkbox"/> OAE-Newborn Testing <input type="checkbox"/> EEG Routine <input type="checkbox"/> EEG Ambulatory <input type="checkbox"/> EEG-Long-term monitor and video with inpatient admission for 24 to 72 hours <input type="checkbox"/> Sleep-deprived EEG <input type="checkbox"/> Sweat conductivity		
Patients scheduled for Cardiopulmonary exams will report to the Cardiopulmonary department located at the South Entrance. Please include patient demographics and chart notes for all Cardiopulmonary studies.					

PHYSICIAN SIGNATURE IS REQUIRED

Physician Signature	Printed Name	Date	Time
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