FAX SCHEDULING

Salem RADIOLOGY CONSULTANTS, P.C.

Please fax this form to SRC at (503) 371-0777
and we will call the patient to schedule the exam.

Phone: (503) 399-1262

Patient: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Ordering Physician: _____ CC to: _____

Clinical Information / Diagnosis: _____

URGENCY OF EXAM: ☐ ASAP ☐ 24-48 HOURS ☐ OTHER

☐ ROUTINE REPORT ☐ FAX REPORT ☐ WET READ

Phone Report To: _____ Fax Report To: _____

Insurance: _____ Authorization #_____

☐ **CT-64 SCAN** (SPECIFY):_____

If patient is over 60 or diabetic and has creatinine lab values within the last 6 weeks performed at a lab other than the Salem Hospital, please fax lab report to 503.763-7477 otherwise SRC will obtain current creatinine lab values at our facility.

☐ Walk-in CT or ☐ Call to Schedule

See reverse side for walk-in CT information

☐ **MRI/MRA** (SPECIFY): _____

HEART PACEMAKER ** Patients with a pacemaker **CAN NOT have an MRI study

Ordering Physician: Please indicate any known contraindicators below to help ensure the patient's safety

TO BE COMPLETED BY SRC SCHEDULING STAFF WITH THE PATIENT

SRC's CT-64 scanner can accommodate patients up to 500 pounds

	YES	NO
FOR IV CONTRAST STUDIES		
IODINE ALLERGY	____	____
ASTHMA	____	____
DIABETIC	____	____

*If contrast, patient exam preparation is clear liquids only 4 hours prior to exam.

PLEASE IDENTIFY ALL CONTRAINDICATORS

	YES	NO
Pacemaker	____	____
Artificial Valves	____	____
Neurostimulator	____	____
Aneurysm Clips	____	____
Cochlear Implants	____	____
Surgically Implanted Metal	____	____
Metal in Eyes	____	____
Worked w/ metal lathes/grinders	____	____
History of welding	____	____
Claustrophobia	____	____

Previous Injury
When: _____
How: _____

Previous Surgery
Date: _____