Patient Referral

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

Appointment Date: _____

Check In Time: _____

Appointment Time: _____

Patient Name: _____ Date of Birth: _____

Patient Phone#: _____

Date of next appointment with Physician: _____

Ordering Physician: _____ _____
PRINTED NAME SIGNATURE

Physician Location: _____

CC Physician: _____

CC Physician Location: _____

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.

Reporting Instructions:

- ❑ Routine Report
- ❑ STAT Phone Results
  Direct Phone # _____
  Have Patient: ❑ Wait ❑ Leave
- ❑ STAT Fax
  Fax # _____

Indicate patient preparation below.

Patient Preparation:

MRI No preparation is necessary / Metal precautions apply.

CT / CT Angio (CTA) If your C.T. involves the injection of contrast material, have clear liquids only for 2 hours prior to your exam. *Patients must weigh less than 500 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.

❑ **POST VOID RESIDUAL:** (Bladder)
32 oz. of water finished 1/2 hour prior to exam.
No voiding until exam is complete.

❑ **RENAL:** 16 oz. of water finished 1/2 hour prior to exam.

❑ **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
- CAROTID
- THYROID
- SHOULDER
- TESTICULAR
- OTHER MUSCULOSKELETAL

Bone Densitometry (DEXA) Scans On the day of your exam, do not take any calcium tablets or TUMS.
Patients 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.# _____

Insurance Information will be needed at each visit.

On Job or Auto Claim? Y N Injury Date: _____

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

Visit us on-line at www.salemradiology.net

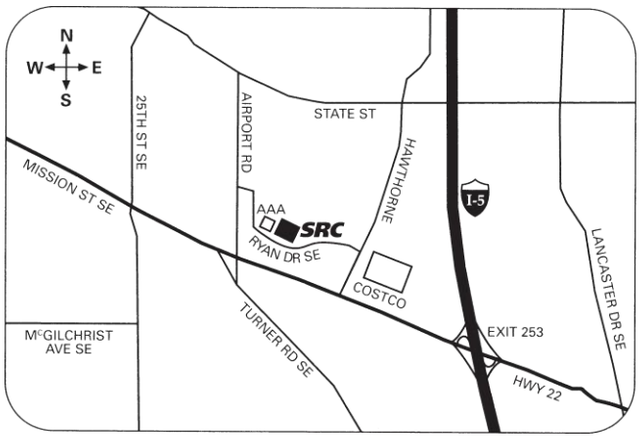
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURANCE Medical Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary and secondary insurance company as a courtesy to you after receiving a copy of your current insurance card. If you have a balance on your account, we will send you a monthly statement after your insurance has been billed. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance which may include the full amount of charges if the insurance company denies coverage. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from the insurance company.

FINANCE CHARGE AND PAST DUE ACCOUNTS A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of one point zero percent (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). If your account becomes past due, we will take all necessary steps to collect the account balance which may include referral to an independent collection agency.

SIGNED:_____ DATE: _____



Our Location:

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www.salemradiology.net