McKenzie-Willamette
MEDICAL CENTER
extraordinary care

Phone:541-726-4462/541-747-4357 Fax:541-744-6053

DIAGNOSTIC IMAGING OP ORDER FORM

Appointment Date:_____Time:_____

Patient Name:_____

DOB:_____ SSN:_____

Exam:_____

☐ May add/change at Radiologist Discretion

Body part to be examined:_____

Sedation: ☐ General ☐ MAC ☐ Moderate/Conscious ☐None

Diagnosis:_____

Complete remainder of form for MRI's ONLY:

	YES	NO
Is Patient Claustrophobic?	_____	_____
Cardiac Pacemaker?	_____	_____
Metal in Eyes?	_____	_____
Intracranial Clips?	_____	_____
Tattoos in area to be Examined?	_____	_____

Physician Signature:_____

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