MISSION MEDICAL IMAGING

1155 MISSION ST. S.E. #105
SALEM, OR. 97302
503-362-0254
FAX 503-362-1082

MAP AND DIRECTIONS ON REVERSE

Appt Date _____ Appt Time _____

PATIENT NAME _____ DOB _____

CLINICAL DIAGNOSIS _____ ICD-9 CODE: _____

STAT RESULT REPORT? _____ ***YES*** ____ ***NO*** ***NUMBER TO REACH YOU:*** _____

REFERRING PHYSICIAN SIGNATURE: _____
(REQUIRED)

CC to DR. _____

PLAIN FILM X-RAY OF: _____

BUN: _____
CREATININE: _____
DATE: _____

CONTRAST USE TO BE DETERMINED BY RADIOLOGIST BASED ON CLINICAL INDICATIONS ____ YES ____ NO

CT

BRAIN

SINUS SCREEN

SOFT TISSUE NECK

TEMPORAL BONE

CHEST

ABDOMEN (COVERAGE FROM XIPHOID TO ILIAC CREST)

PELVIC (CREST TO PUBIS)

RENAL (KIDNEY STONE)

CERVICAL SPINE LEVELS _____

THORACIC SPINE LEVELS _____

LUMBAR SPINE LEVELS _____

VIRTUAL COLONOSCOPY*

* May not be covered by insurance.

MRI

BRAIN

NECK - SOFT TISSUE

C-SPINE

T-SPINE

L-SPINE

UPPER EXTREMITY

LOWER EXTREMITY

PELVIS/HIPS

ABDOMEN

MRA
HEAD ____

NECK ____

OTHER _____

_____

NUCLEAR MEDICINE

WHOLE BODY BONE SCAN

BONE SCAN-LIMITED REGION

THREE PHASE BONE SCAN

SPECT

GASTRIC EMPTYING

THYROID SCAN/UPTAKE

BILIARY STUDY (HIDA) W/FLOW

PARATHYROID

LUNG SCAN

RBC LIVER

RENAL SCAN WITH FLOW

MUGA SCAN

MYOCARDIAL - REST/STRESS

_____

ULTRASOUND

ABDOMEN

AORTA SCREENING

RENAL - KIDNEYS

RENAL VASCULAR

PELVIS AND TRANSVAGINAL EXAM

OBSTETRICAL
(Early OB may include transvaginal)

AFI/PLACENTAL POSITION/ FETAL POSITION

CAROTID DUPLEX

VENOUS EXTREMITY (DVT)

SHOULDER

BREAST

TESTICLE

THYROID

THYROID BIOPSY

APPENDIX

HERNIA _____
(Location)

OTHER _____