

MT. SCOTT

DIAGNOSTIC IMAGING

Your Imaging Partner

9200 SE 91st Ave. Suite 330 Portland OR 97086 • 503.774.7700 Office • 503.774.7701 Fax

www.mtscottimaging.com

Patient Name _____ Date/Time of Exam _____

Ordering Dr. _____

Symptoms _____ Comments _____

<input type="checkbox"/> MRI Brain	<input type="checkbox"/> W&W/O Contrast	<input type="checkbox"/> MRI Shoulder	L	R
<input type="checkbox"/> MRI Pituitary		<input type="checkbox"/> MRI Elbow	L	R
<input type="checkbox"/> MRI IAC		<input type="checkbox"/> MRI Wrist	L	R
<input type="checkbox"/> MRI Cervical	<input type="checkbox"/> W&W/O Contrast	<input type="checkbox"/> MRI Hand	L	R
<input type="checkbox"/> MRI Thoracic	<input type="checkbox"/> W&W/O Contrast	<input type="checkbox"/> MRI Hip	L	R
<input type="checkbox"/> MRI Lumbar	<input type="checkbox"/> W&W/O Contrast	<input type="checkbox"/> MRI Femur	L	R
<input type="checkbox"/> MRI TMJ		<input type="checkbox"/> MRI Knee	L	R
<input type="checkbox"/> MRI Soft Tissue Neck		<input type="checkbox"/> MRI Tib-Fib	L	R
<input type="checkbox"/> MRI Abdomen		<input type="checkbox"/> MRI Ankle	L	R
<input type="checkbox"/> MRI Pelvis		<input type="checkbox"/> MRI Foot	L	R
<input type="checkbox"/> MRA Brain/COW		<input type="checkbox"/> MRI Other _____		
<input type="checkbox"/> MRA Neck/Carotids		<input type="checkbox"/> MR Arthrogram Shoulder	L	R
<input type="checkbox"/> MRA Renal		<input type="checkbox"/> MR Arthrogram Wrist	L	R
<input type="checkbox"/> MRV Brain		<input type="checkbox"/> MR Arthrogram Hip	L	R
<input type="checkbox"/> MRA Other _____				

<input type="checkbox"/> X-RAY Orbit Screening 1V	<input type="checkbox"/> X-RAY Shoulder	L	R
<input type="checkbox"/> X-RAY Facial / Sinus	<input type="checkbox"/> X-RAY Elbow	L	R
<input type="checkbox"/> X-RAY Neck Soft Tissue	<input type="checkbox"/> X-RAY Wrist	L	R
<input type="checkbox"/> X-RAY Chest 2V PA/LAT	<input type="checkbox"/> X-RAY Hand	L	R
<input type="checkbox"/> X-RAY Ribs Bilateral / Unilateral	<input type="checkbox"/> X-RAY Pelvis / Hip	L	R
<input type="checkbox"/> X-RAY Abdomen Upright / Supine	<input type="checkbox"/> X-RAY Knee	L	R
<input type="checkbox"/> X-RAY Cervical Spine 3V, 5V, 7V	<input type="checkbox"/> X-RAY Ankle	L	R
<input type="checkbox"/> X-RAY Thoracic Spine	<input type="checkbox"/> X-RAY Foot	L	R
<input type="checkbox"/> X-RAY Lumbar Spine 3V, 5V, 7V	<input type="checkbox"/> X-RAY Other _____		
<input type="checkbox"/> X-RAY Spine LAT 1V			

*Notify the center before your exam if you have a cardiac pacemaker, aneurysm clips or if you are at risk for having metallic foreign body in your eyes.

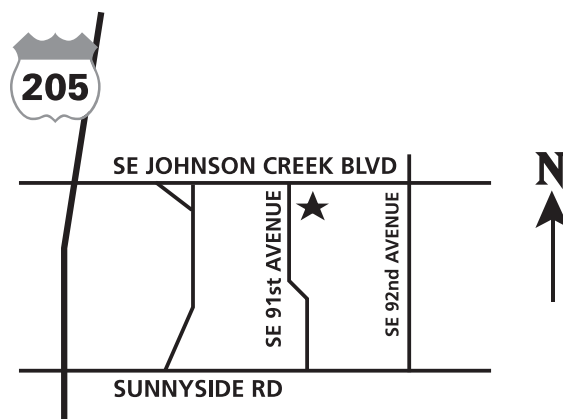
*Please bring this form and your insurance card to your exam.



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From Interstate 205, take the SE Johnson Creek Blvd. exit, and proceed East off the exit. Follow up the hill about on half mile to SE 91st Avenue, and take a Right. We are located in the Mt. Scott Professional Building on the Left. The parking lot is easy to identify.

Mt. Scott Diagnostic Imaging
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