

**SCHEDULE BY PHONE, FAX OR EMAIL:****P:** 503.253.1105 **F:** 503.535.8394**E:** scheduling@epicimaging.com Patient will call to schedule  Call patient to schedule**Chiropractic Order Form**

- Bethany
- Gateway
- Hall/Nimbus
- Happy Valley

Appointment date and time		Check-in time	
Patient name (as shown on insurance card)		Primary phone	Secondary phone
Patient DOB	<input type="radio"/> M <input type="radio"/> F	Authorization #	Authorization insurance phone
Insurance		Insurance ID #	Group #
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private		Date of injury	Attorney name/Claim #

**(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s).** Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.**Is the exam/procedure related to an injury?**  No  Yes **If yes,**  Initial,  Subsequent or  Sequela

Area of body	<input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> B
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MRI
<input type="radio"/> IV contrast as clinically indicated by radiologist <b>OR</b> <input type="radio"/> No contrast
<input type="radio"/> MRI
<input type="radio"/> High-field MRI <input type="radio"/> 3T MRI <input type="radio"/> Open MRI <input type="radio"/> Angiogram <input type="radio"/> Arthrogram (joint injection)
If you prefer, you may request:
<input type="radio"/> MD read only <b>OR</b> <input type="radio"/> Chiropractic read (includes MD read)

<input type="radio"/> CT
<input type="radio"/> IV contrast as clinically indicated by radiologist <b>OR</b> <input type="radio"/> No contrast
<input type="radio"/> 3D reconstructions as clinically indicated by radiologist <b>OR</b> <input type="radio"/> No 3D reconstructions

<input type="radio"/> X-RAY
Views
<input type="radio"/> Standard _____
<input type="radio"/> Additional _____

NOTES

Previous treatments/Imaging/Exams <input type="radio"/> No <input type="radio"/> Yes What type _____
Patient considerations (check all that apply) <input type="radio"/> Requires transportation <input type="radio"/> Allergies to contrast agents <input type="radio"/> Diabetes <input type="radio"/> Weight consideration
<input type="radio"/> Interpreter needed (language) _____ <input type="radio"/> Renal failure/Dialysis <input type="radio"/> Claustrophobic <input type="radio"/> Sedation (administered by CDI)
<input type="radio"/> Other _____ <i>All patients receiving sedation require a driver.</i>
Lab Results Creatinine _____ BUN _____ Blood draw date _____ <input type="radio"/> On-site creatinine testing needed

<b>REPORTING METHOD:</b> <input type="radio"/> Hold and call _____ <input type="radio"/> Read and call _____ <input type="radio"/> STAT/ASAP
<input type="radio"/> Next-day follow-up <input type="radio"/> Patient to hand carry films/CD <input type="radio"/> Routine

Provider name (print)	Provider location	Phone #
<b>Provider signature (required)</b> <i>Do not use rubber stamp.</i>	<b>NPI # (required)</b> <small>Electronically sent</small>	Date

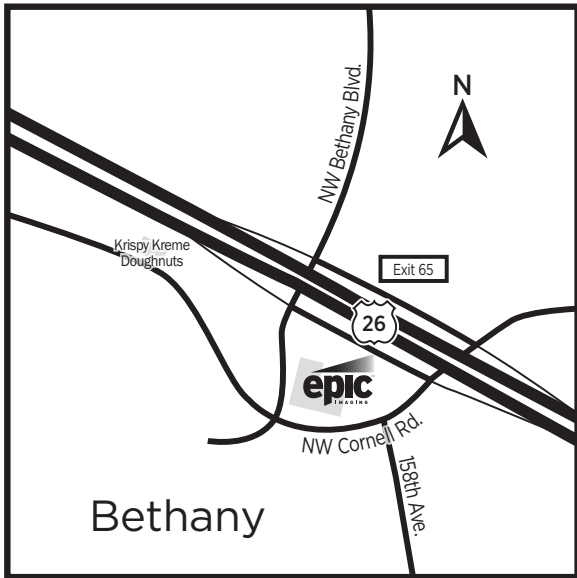
## PATIENT PREPARATION

### Arthrogram • DXA Scan

No preparation is necessary.

### CT • MRI

Please bring prior MRI, CT or X-ray films. Call for instructions: 503.253.1105.



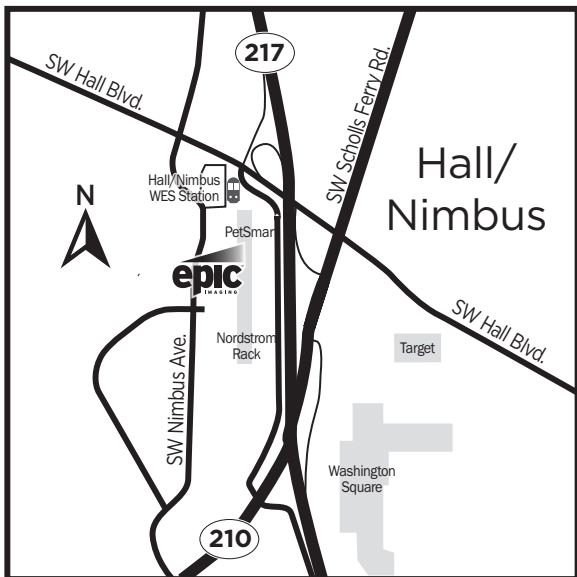
#### BETHANY

1500 NW Bethany Blvd., Suite 100  
Beaverton, OR 97006



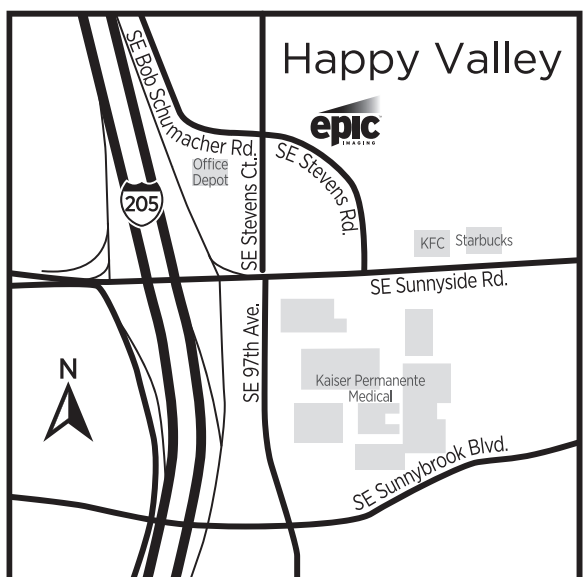
#### GATEWAY

233 NE 102nd Ave.  
Portland, OR 97220



#### HALL/NIMBUS

8950 SW Nimbus Ave.  
Beaverton, OR 97008



#### HAPPY VALLEY

10121 SE Sunnyside Rd., Suite 170  
Clackamas, OR 97015