



Radiology Ltd.
Diagnostic Imaging Services
 Interventional Scheduling Tel: (520)545-1906
 Toll Free 1-866-565-2220

INTERVENTIONAL SCHEDULING

To schedule an appointment, please fax to (520)545-1898.
Please include all relevant chart notes, H & P, and prior imaging reports.

PHYSICIAN'S NAME: _____ PHONE #: (_____) _____ FAX #: (_____) _____
 PATIENT: (First Name) _____ (Last Name) _____ (Middle Initial) _____
 DOB: _____ HOME PHONE: (_____) _____
 WORK PHONE: (_____) _____ BEST TIME TO CONTACT: _____ AM PM
 PATIENT INSURANCE: _____ Ins. Phone: (_____) _____
 POLICY #: _____ GROUP #: _____
 PRIOR AUTHORIZATION # (if needed): _____ Would you like authorization assistance? YES NO

If you would like us to assist in obtaining the authorization, please include all clinicals, history sheets, and progress notes with order.
NOTE: We are unable to provide authorization assistance for STAT cases and APIPA, APIPA Senior, Mercy Care, Cigna, and United Healthcare insurances.

- | | |
|--|--|
| <input type="checkbox"/> Angiogram (Carotid / Cerebral) | <input type="checkbox"/> Nephrostomy |
| <input type="checkbox"/> Angiogram (Visceral / Peripheral) | <input type="checkbox"/> Paracentesis |
| <input type="checkbox"/> Angioplasty (Visceral / Peripheral) | <input type="checkbox"/> Percutaneous Abscess Drainage |
| <input type="checkbox"/> Arthrogram (CT) | <input type="checkbox"/> PICC Line Placement |
| <input type="checkbox"/> Arthrogram (MRI) | <input type="checkbox"/> Sacroplasty |
| <input type="checkbox"/> Arthrogram (Fluoro) | <input type="checkbox"/> Spinal Injection (Epidural) |
| <input type="checkbox"/> Biliary Drain / Stent | <input type="checkbox"/> Spinal Injection (Facet) |
| <input type="checkbox"/> Biopsy (Image Guided Percutaneous) | <input type="checkbox"/> Spinal Injection (Nerve Root) |
| <input type="checkbox"/> Calcium Score (CT) | <input type="checkbox"/> Spinal Injection (Sacroiliac) |
| <input type="checkbox"/> Cardiac (Coronary) CTA | <input type="checkbox"/> Stents (Visceral / Peripheral) |
| <input type="checkbox"/> Fistulogram (Dialysis) | <input type="checkbox"/> Thoracentesis |
| <input type="checkbox"/> IVC Filter Placement | <input type="checkbox"/> Varicose Vein - Laser Treatment |
| <input type="checkbox"/> Joint Injection (Extremity) | <input type="checkbox"/> Venogram |
| <input type="checkbox"/> Lumbar Puncture | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Myelogram (CT) | |

Patient is on the following Anticoagulant(s)

Aspirin
 Coumadin / Warfarin
 Plavix / Effient (Prasugrel)
 Patient is not on Anticoagulant(s)

Patient may discontinue above indicated Anticoagulant(s) 5-7 days before procedure.

Yes Dr. Initials _____
 No Dr. Initials _____

Procedure(s) Requested: _____

Clinical Indication: _____

Special Instructions: _____

Previous Films: YES NO When: _____ Where: _____

Referring Physician's Signature: _____ **Date:** _____

Location, Date & Time of Scheduled Appointment:

DATE: _____ TIME: _____ AM PM

LOCATION: La Cholla Center for Diagnostic Imaging & Treatment
 Wilmot Center for Diagnostic Imaging & Treatment

If you have any questions, please call: (520)545-1906

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