MEN'S SERVICES SCHEDULING

CLEAR

Radiology Ltd.
Diagnostic Imaging Services
Centralized Scheduling Tel: (520) 733-7226
Toll Free Tel: 1-866-565-2220
Toll Free Fax: 1-866-707-0750

To schedule an appointment, please call (520) 733-7226 or fax to (520) 290-8377.

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): _____

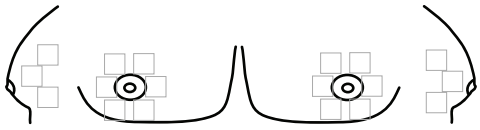
MALE MAMMOGRAPHY

❑ Diagnostic Digital Mammography w/CAD
(and Ultrasound if indicated)

Please check appropriate clinical indications:

- ❑ Pain
- ❑ Nipple Discharge / Inversion / Retraction or Thickening
- ❑ Contusion
- ❑ Gynecomastia / Enlargement
- ❑ 6 Months Follow-up ❑ RT ❑ LT
- ❑ Mass
- ❑ Other: _____

Please indicate area of concern:



Right Left

Date of last Mammogram: _____

Location of last Mammogram: _____

History / Indications:

PATIENT INSTRUCTIONS: Please bring this prescription to your appointment. Avoid wearing deodorant or powder.

Please check the Radiology Ltd. office preferred:

- ❑ Wilmot Center
- ❑ La Cholla Center

MALE DEXA

Please check appropriate clinical indications:

- ❑ Anti-convulsant Therapy*
- ❑ Follow-up Treatment for Prevention / Monitoring of Osteoporosis
- ❑ Long Term Thyroid Treatment
- ❑ Long Term Steroid Treatment
- ❑ Loss of Height (or Family History)*
- ❑ Rheumatoid Arthritis*
- ❑ Suspicion of Poor Calcium Intake*
- ❑ Vertebral Abnormalities
- ❑ Other: _____

** This is not a payable diagnosis and insurance **may not** cover this exam.*

Date of last DEXA: _____

Location of last DEXA: _____

History / Indications:

PATIENT INSTRUCTIONS: Please bring this prescription to your appointment. Avoid taking vitamins, minerals, and calcium supplements on the day of your Bone Density (DEXA) Exam.

Please check the Radiology Ltd. office preferred:

- ❑ Wilmot Center
- ❑ La Cholla Center
- ❑ Rancho Vistoso Center

Notes:

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

PRINT