CT & MRI SCHEDULING

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 #: (______) ____________

If physician practices at multiple locations, please include address for these results to be sent: ______________________

PATIENT: (First Name) ____________________ (Last Name) ____________________ (Middle Initial) ________

DOB:__________ HOME PHONE: (_____) ____________ WORK PHONE: (_____) ____________ BEST TIME TO CONTACT: ______ AM PM

PATIENT INSURANCE: ______________ POLICY/GROUP#: ____________________ INS. PHONE: (_____) ____________

PRIOR AUTHORIZATION # (if needed): ____________________ Would you like authorization assistance? ❑ YES ❑ NO

If you would like authorization assistance, please include all clinical information and a copy of the insurance card with the order.
Please note: *We are unable to provide authorization assistance for STAT cases and CareMore, Humana and United Healthcare insurance plans.*

Please check which Radiology Ltd. office preferred: ❑ Eastside ❑ Central ❑ Northwest ❑ Oro Valley ❑ Southwest

EXAM

- ❑ MRI
- ❑ MRA
- ❑ CT
- ❑ CTA

SPECIALTY EXAM

- ❑ CT CALCIUM SCORE *(Wilmot)*
- ❑ CTA CARDIAC
- ❑ MR CARDIAC
- ❑ MR PROSTATE MULTIPARAMETRIC W/3D RECON *(Camp Lowell)*
- ❑ CT IVP - UROGRAM
- ❑ CT VIRTUAL COLON *(Camp Lowell)*
- ❑ CT LUNG SCREENING
- ❑ ENTEROGRAPHY
  - ❑ CT *(All locations)*
  - ❑ MRI *(Wilmot, Camp Lowell, La Cholla, & Rancho Vistoso)*

BODY PART

- ❑ BRAIN
  - ❑ with NeuroQuant® (3D volumetric analysis)
  - ❑ Pituitary (MRI)
  - ❑ Post Fossa / IAC (MRI)
  - ❑ Orbits
- ❑ SINUSES with reconstruction
- ❑ NECK (soft tissue)
- ❑ TEMPORAL BONES
- ❑ FACIAL BONES (CT)
- ❑ TMJ (MRI preferred, CT second)
- ❑ CERVICAL SPINE
- ❑ THORACIC SPINE
- ❑ LUMBAR SPINE
- ❑ CHEST
- ❑ ABDOMEN
- ❑ PELVIS (Body)
- ❑ PELVIS (MSK)
- ❑ EXTREMITY

EXTREMITY	Left	Right
❑ Shoulder	❑	❑
❑ Elbow	❑	❑
❑ Wrist	❑	❑
❑ Hand	❑	❑
❑ Hip	❑	❑
❑ Knee	❑	❑
❑ Ankle / Hindfoot	❑	❑
❑ Forefoot	❑	❑
❑ 3D Reconstructions		

SYMPTOMS

- ❑ Headache
- ❑ TIA
- ❑ CVA
- ❑ Stenosis
- ❑ Dizziness
- ❑ Ataxia
- ❑ Syncope
- ❑ Seizure Disorder
- ❑ Disc Disorder
- ❑ Stenosis
- ❑ Fracture
- ❑ Back Pain
- ❑ Radiculopathy
- ❑ Other

(Please indicate symptoms on the lines below)

Has patient had 6 weeks or more of unsuccessful pain management measures? ❑ YES ❑ NO

Check all that apply: ❑ NSAIDs ❑ Physical Therapy

Primary Diagnosis: ____

Signs & Symptoms: ____

Special Instructions: ____

Does the patient need IV sedation? ❑ YES ❑ NO

Any known allergies to X-ray dye (Contrast)? ❑ YES ❑ NO

Does the patient have kidney disease / renal failure? ❑ YES ❑ NO If yes, dialysis? ❑ YES ❑ NO If yes, next appt: ____________

Previous Films: ❑ YES ❑ NO When: ____________________ Where: ____________________

❑ Stat Report Requested ❑ Fax report to: (_______)____________________

❑ Call Report Requested (cell phone, pager number, or office backline required): (_______)____________________

Referring Physician's Signature: ______________________________ **Date:** ____________

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