PHOENIX ER & MEDICAL HOSPITAL

Diagnostic Imaging Order Form

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Appointment Date & Time: _____

Prep Instructions Given: ☐ Yes (Specify): _____ ☐ No ☐ N/A

Patient Information

Name: _____ **Date of Birth:** ___/___/___ **Weight:** _____ lb / kg

Insurance/Policy #: _____ **Pre-Authorization #/Date Range:** _____

Ordering Physician: _____ **Phone:** _____

Physician Signature: _____ **NPI #:** _____ **Date:** _____

Clinical Reason for Exam (including ICD 10 codes): _____

_____

Physician Preference for Results: ☐ Report Only ☐ Report and CD ☐ Routine ☐ STAT

Fax: _____ **Other:** _____

X-Ray	☐ Skull ☐ Orbits ☐ Sinuses ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Chest (○AP & L) (○PA) ☐ Abdomen ☐ Pelvis ☐ Ribs (○L) (○R) ☐ Hip (○L) (○R) ☐ Extremity/Joint: _____ (○L) (○R) (○Bilat.) (○Upper) (○Lower) ☐ Other (specify): _____
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain ☐ Orbits ☐ Sinus ☐ Neck (Soft Tissues) ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Chest ☐ Abdomen/Pelvis ☐ Abdomen Only ☐ Pelvis Only ☐ Extremity: _____ (○L) (○R) (○Bilat.) (○Upper) (○Lower) ☐ Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
MRI ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Brain MRI ☐ Brain MRA ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Neck MRA ☐ IAC ☐ Orbits ☐ Neck (Soft Tissue) ☐ MRCP ☐ Abdomen ☐ Pelvis ☐ Shoulder (○L) (○R) ☐ Hip (○L) (○R) ☐ Knee (○L) (○R) ☐ Ankle (○L) (○R) ☐ Extremity other (specify): _____ (○L) (○R) (○Bilat.) (○Upper) (○Lower) ☐ Check Box if claustrophobic ☐ Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
Ultrasound	☐ Complete Abdomen ☐ Limited Abdomen (specify): _____ ☐ OB/TV - 1st Trimester ☐ Limited OB - Follow ☐ OB - Fetal Bio Physical Profile ☐ Pelvis ☐ Gallbladder ☐ Renal ☐ Bladder ☐ Scrotum ☐ Thyroid ☐ Carotid ☐ Aorta ☐ Venous: ☐ Upper Extremity (○L) (○R) (○Bilateral) ☐ Lower Extremity (○L) (○R) (○Bilateral) ☐ Arterial ☐ Upper Extremity (○L) (○R) (○Bilateral) ☐ Lower Extremity (○L) (○R) (○Bilateral) ☐ Other (specify): _____

This form must be completed, signed by physician, and presented to the Phoenix ER and Medical Hospital outpatient registration desk prior to any test being performed. Thank You!