

*Required

DATE*: _____ PATIENT NAME*: _____ DOB*: _____

CLINICAL HISTORY*: _____

PHYSICIAN SIGNATURE*: _____ PRINT*: _____

PATIENT PHONE*: _____ LANGUAGE PREFERENCE: English Spanish

INSURANCE INFO NEEDED AT THE TIME OF SCHEDULING*:

INSURANCE: _____ INS. ID: _____ INS. AUTH: _____ Obtain Prior Auth.

Prior Studies Yes No If yes, Exam / Location / Date: _____

PRIORITY:		MEDIA:	
<input type="checkbox"/> ROUTINE <input type="checkbox"/> STAT <input type="checkbox"/> CALL REPORT _____		<input type="checkbox"/> CD w/Patient	
PET/CT		ULTRASOUND	
<input type="checkbox"/> Head to Mid-Thigh FDG 78815 <input type="checkbox"/> Whole Body FDG 78816 <input type="checkbox"/> Limited FDG 78814 <input type="checkbox"/> NaF Bone Scan 78816 <input type="checkbox"/> FDG Brain (AD vs FTD) 78608 <input type="checkbox"/> Axumin 78815	<input type="checkbox"/> Abdomen <input type="checkbox"/> AAA Screening <input type="checkbox"/> Appendix <input type="checkbox"/> Renal/Bladder <input type="checkbox"/> Renal w/Post Void Residual <input type="checkbox"/> Renal w/Arterial Duplex <input type="checkbox"/> Scrotal <input type="checkbox"/> Groin <input type="checkbox"/> Pelvic w/Transvaginal PRN <input type="checkbox"/> Male Pelvic <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> OB w/Transvag (1st trimester) <input type="checkbox"/> OB (2nd/3rd trimester) <input type="checkbox"/> Carotid Duplex <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft Tissue Head/Neck <input type="checkbox"/> Thyroid Biopsy <input type="checkbox"/> Upper Extremity Venous <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Lower Extremity Venous <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Lower Extremity Arterial Segmental Pressures <input type="checkbox"/> ABI <input type="checkbox"/> Other: _____	<input type="checkbox"/> Head <input type="checkbox"/> W/ Contrast* <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> W/WO Contrast* <input type="checkbox"/> Chest <input type="checkbox"/> W/O Contrast <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Per Radiologist* <small>*includes Creatinine if indicated</small>	
MRI		CT	
<input type="checkbox"/> Brain <input type="checkbox"/> w/MS protocol <input type="checkbox"/> IAC <input type="checkbox"/> Pituitary <input type="checkbox"/> NeuroQuant w/3D Rendering <input type="checkbox"/> Orbits <input type="checkbox"/> 3T Only <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Open/Short Bore <small>(for claustro patients)</small> <input type="checkbox"/> Chest <input type="checkbox"/> W/WO Contrast* <input type="checkbox"/> Abdomen <input type="checkbox"/> WO Contrast <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Per Radiologist* <input type="checkbox"/> Enterography <input type="checkbox"/> Arthrogram <small>*includes Creatinine if indicated</small>	<input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Bony <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Prostate <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Sacrum <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib <input type="checkbox"/> Ankle/Hindfoot <input type="checkbox"/> Forefoot <input type="checkbox"/> Heel <input type="checkbox"/> Other: _____	<input type="checkbox"/> Temporal Bones <input type="checkbox"/> Sinus <input type="checkbox"/> Medtronic <input type="checkbox"/> Stryker <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Sacrum <input type="checkbox"/> Bony Pelvis <input type="checkbox"/> Urography w/3D <input type="checkbox"/> Enterography <input type="checkbox"/> Low Dose Lung Screening *Must follow requirements for ordering <input type="checkbox"/> Virtual Colonoscopy (self pay) <input type="checkbox"/> Calcium Score (self pay) <input type="checkbox"/> Other: _____	
MRA		CTA	
<input type="checkbox"/> Carotid <input type="checkbox"/> Intracranial (COW) <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Renal <input type="checkbox"/> Thoracic Aorta <input type="checkbox"/> Abdominal Aorta w/Runoff	<input type="checkbox"/> Brain <input type="checkbox"/> Carotids (Neck/Brain) <input type="checkbox"/> Pulmonary (PE) <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Renal <input type="checkbox"/> Thoracic Aorta <input type="checkbox"/> Entire Aorta (Chest/Abdomen/Pelvis) <input type="checkbox"/> Abdominal Aorta w/Runoff <input type="checkbox"/> Coronary <input type="checkbox"/> Other: _____		
DXA / BONE DENSITY		X-RAY (Walk-in, No appointment necessary)	
<input type="checkbox"/> DXA/Bone Densitometry <input type="checkbox"/> DXA/Bone Densitometry w/Vertebral Assessment <input type="checkbox"/> Body Composition (self pay)	<input type="checkbox"/> Screening Mammogram* <input type="checkbox"/> 3D Screening Mammogram* <small>Sunwest Breast Center only</small> <input type="checkbox"/> Diagnostic Mammogram** <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> 3D Diagnostic Mammogram** <small>Sunwest Breast Center only</small> <small>*With permission to convert to diagnostic exam (additional images and/or ultrasound as indicated per radiologist)</small> <small>**With ultrasound as indicated per radiologist</small> <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <small>(mammogram if indicated)</small> <input type="checkbox"/> Breast MRI-3D rendering w/wo Gad <input type="checkbox"/> Core Biopsy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> w/US <input type="checkbox"/> w/MRI <input type="checkbox"/> Stereotactic Breast <input type="checkbox"/> Axilla Biopsy/FNA <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Other: _____	<input type="checkbox"/> CXR <input type="checkbox"/> 2V <input type="checkbox"/> 1V <input type="checkbox"/> Abdomen <input type="checkbox"/> KUB <input type="checkbox"/> 2V (flat/upright) <input type="checkbox"/> Sinus <input type="checkbox"/> Waters <input type="checkbox"/> Series <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Knee <input type="checkbox"/> WB <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Foot <input type="checkbox"/> WB <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Ankle <input type="checkbox"/> WB <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Hip w/Pelvis <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Pelvis 1V <input type="checkbox"/> C Spine <input type="checkbox"/> T Spine <input type="checkbox"/> L Spine <input type="checkbox"/> Scoliosis <input type="checkbox"/> Complete <input type="checkbox"/> 2-3V <input type="checkbox"/> Flex/Ext <input type="checkbox"/> WB <input type="checkbox"/> Other: _____	
NUCLEAR MEDICINE		FLUOROSCOPY	
BONE SCAN: <input type="checkbox"/> Whole Body <input type="checkbox"/> 3-Phase <input type="checkbox"/> SPECT/CT P1 ONLY <input type="checkbox"/> SPECT <input type="checkbox"/> LTD InWBC w/Bone Marrow if indicated Indicate Area of Interest _____ _____ Parathyroid <input type="checkbox"/> Planar <input type="checkbox"/> SPECT <input type="checkbox"/> SPECT/CT P1 ONLY	<input type="checkbox"/> DaTscan Brain SPECT (Parkinson's) <input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> HIDA w/CCK & Gallbladder US if indicated <input type="checkbox"/> Renal Scan w/Lasix <input type="checkbox"/> V/Q Scan w/CXR if indicated <input type="checkbox"/> Other: _____	<input type="checkbox"/> Esophagram <input type="checkbox"/> UGI w/AIR <input type="checkbox"/> Barium Enema <input type="checkbox"/> Barium Enema w/AIR <input type="checkbox"/> Small Bowel <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> VCUG <input type="checkbox"/> Arthrogram _____ <input type="checkbox"/> Other: _____	

VALLEY RADIOLOGISTS LOCATIONS and SERVICES

Central Scheduling: Phone 623-847-2000 • Fax 623-847-2001

Hours vary by location. Please confirm with Central Scheduling. Extended and weekend hours available for some exams/locations.

• Schedule your appointment online at valleyradiologists.com • Walk-in X-Ray, No appointment necessary •

18275 North 59th Avenue, Suite K-168
Glendale, AZ 85308
HOURS: M-F 8am-5pm

ARROWHEAD COMMONS

Digital Screening Mammography, Ultrasound, X-Ray, Bone Density (DXA)

13909 West Camino Del Sol, Suite 101, Sun City West, AZ 85375
HOURS: M-F 7am-6pm • Sat 7am-1pm
MRI Sun 7am-4pm by appointment only

CAMINO DEL SOL OFFICE

3T MRI, CT, CTA, Digital Screening & Diagnostic Mammography, Ultrasound, Breast Ultrasound, Ultrasound Breast Biopsy, Ultrasound-guided Thyroid Biopsy, Digital Fluoroscopy, X-Ray, Bone Density (DXA)

9305 West Thomas Road, Suites 100 & 200, Phoenix, AZ 85037
HOURS: M-F 7am-6pm • Sat 7am-1pm
Breast Center: M-F 7am-5pm • Sat 7am-12pm

ESTRELLA OFFICE
ESTRELLA BREAST CENTER

MRI, Breast MRI, CT, CTA, Digital Screening & Diagnostic Mammography, Ultrasound, Breast Ultrasound, Ultrasound & Stereotactic Breast Biopsy, Interventional Breast Services, Ultrasound-guided Thyroid Biopsy, X-Ray, Bone Density (DXA)

13555 West McDowell Road, Suite 106, Goodyear, AZ 85395
HOURS: M-Th 7am-7pm • Fri 7am-6pm • Sat 7am-1pm
MRI Sun 7am-4pm by appointment only

PALM VALLEY OFFICE

3T MRI, 1.5MRI, CT, CTA, Digital Screening Mammography, Ultrasound, X-Ray, Bone Density (DXA), Nuclear Medicine (SPECT)

16641 North 40th Street, Suite 1
Phoenix, AZ 85032
HOURS: M-F 7am-6pm • Sat 7am-1pm

PARADISE VALLEY OFFICE
PARADISE VALLEY BR CTR

3T MRI, Breast MRI, CT, CT Colonography, CTA, Digital Screening & Diagnostic Mammography, Ultrasound, Breast Ultrasound, Ultrasound & Stereotactic Breast Biopsy, Interventional Breast Services, Ultrasound-guided Thyroid Biopsy, Digital Fluoroscopy, X-Ray, Bone Density (DXA), PET/CT

5601 West Eugie Avenue, Suite 102, Glendale, AZ 85304
5605 West Eugie Avenue, Suite 110, Glendale, AZ 85304
HOURS: PASEO I: M-F 7am-5pm • Sat 7:30am-4pm
PASEO II: M-Fri 7am-7:30pm • Sat/Sun* 7am-4pm *Sunday MRI ONLY

PASEO I OFFICE
PASEO II OFFICE

3T MRI, 1.5T MRI, Breast MRI, CT, CTA, Coronary CTA, PET/CT, Ultrasound, Digital Fluoroscopy, X-Ray, Nuclear Medicine (SPECT/CT)

5757 West Thunderbird Road, Suites W100 & W101, Glendale, AZ 85306
HOURS: M-F 7am-5pm
Breast Center: M-F 7am-5pm • Sat 7:30am-12pm

SUNWEST OFFICE
SUNWEST BREAST CENTER

2D & 3D Screening & Diagnostic Mammography, Breast Ultrasound, Stereotactic & Ultrasound Breast Biopsy & other Interventional Breast Services, Ultrasound-guided Thyroid Biopsy, Bone Density (DXA), X-Ray.

5310 West Thunderbird Road, Suite 100
Glendale, AZ 85306
HOURS: M-F 8am-5pm

THUNDERBIRD OFFICE

Ultrasound, X-Ray

18444 North 25th Avenue, Suite 140
Phoenix, AZ 85023
HOURS: M-F 7am-6pm

UNION HILLS OFFICE

3T MRI, 1.5T MRI, CT, CTA, Digital Screening Mammography, Ultrasound, Digital Fluoroscopy, X-Ray, Bone Density (DXA)

Central Scheduling
Phone: 623.847.2000

Central Fax Scheduling
Fax: 623.847.2001

PATIENT NAME: _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

WWW.VALLEYRADIOLOGISTS.COM