



Arizona Advanced Imaging



Phoenix
MRI, CT, US, X-RAY
 2225 W Peoria Ave, Unit 150
 Phoenix, AZ 85029
 PH **602-753-4860**
 F **602-715-1510**

Scottsdale
MRI ONLY
 9787 N 91st St • Unit 101
 Scottsdale, AZ 85258
 PH **480-927-3887**
 F **480-779-1370**

Mesa
MRI, CT, US, X-RAY
 4566 E Inverness Ave, Ste 102
 Mesa, AZ 85206
 PH **480-308-7718**
 F **480-308-7717**

Chandler
MRI, CT, US, X-RAY
 600 S Dobson Rd, Ste E42
 Chandler, AZ 85224
 PH **480-306-7008**
 F **480-306-7316**

Tucson
MRI, CT, US, X-RAY
 6261 N La Cholla Blvd, Ste 161
 Tucson, AZ 85741
 PH **520-783-2300**
 F **520-532-2026**

Please bring this completed order, your insurance card, and a photo ID with you to your appointment.

Today's date: _____ Appointment date: _____ Appointment time: _____

Patient Name: _____ DOB: ____/____/____ M or F Patient Phone: _____
(last) (first) MM DD YYYY

Diagnosis/Current Symptoms/History: _____ ICD 10 Code: _____

Physician Signature: _____ Phone: _____ Fax: _____

Print Physician Name: _____

Attorney Name: _____ Phone: _____ Fax: _____

Insurance carrier: _____ ID #: _____

MRI
(with reconstruction as indicated)

Brain SWI
 Brain & IAC TBI
 Brain & Pituitary DTI
 IAC Only ALAR
 Pituitary Only
 Orbits
 Neck Soft Tissue
 Spine:
 cervical _____
 thoracic _____
 lumbar _____
 Abdomen (indicate area of interest below)

MRCP
 Adrenals
 Pelvis

Extremity: left _____ right _____
 body part: _____

Other:

Without contrast
 With & without contrast

MR Angiography (MRA)
 Brain
 Neck - Carotids
 Chest
 Renals
 Other:

Without contrast
 With & without contrast

CT
(with reconstruction as indicated)

Head / Brain
 Temporal Bones (IAC's)
 Sinus (Maxillofacial)
 complete _____ limited _____
 Maxillofacial – Facial Bones
 Neck Soft Tissue
 Shoulder: left _____ right _____
 Spine:
 cervical _____
 thoracic _____
 lumbar _____
 Chest
 Abdomen (pelvis as indicated)
 Pelvis
 CT Urogram
 CT Stone Protocol
 Hip: left _____ right _____
 Extremity: left _____ right _____
 Indicate area of interest: _____

Other:

With contrast
 Without contrast
 With & without contrast

CT Angiography (w & w/o contrast)
 Head / Brain
 Neck - Carotids
 Chest
 Abdomen (pelvis as indicated)
 Pelvis
 Other:

X-RAY

Skull
 Orbits
 Sinuses:
 waters _____
 limited _____
 complete _____
 Shoulder: left _____ right _____
 Neck Soft Tissue
 Chest: PA _____ PA/LAT _____
 Ribs (w/ PA Chest):
 left _____ right _____
 Spine: Add Flex/Ext
 cervical _____
 thoracic _____
 lumbar _____
 KUB
 Acute Abdominal Series
 Hip: left _____ right _____
 Bilateral Hips (w/ pelvis)
 Pelvis
 Indicate area of interest: _____
 Extremity: left _____ right _____

Other:

ULTRASOUND
(with Doppler as indicated)

Carotid Doppler
 Venous Doppler
 upper extremity: left _____ right _____
 lower extremity: left _____ right _____

Abdominal Aorta
 Abdomen
 Abdomen Limited:
 gallbladder _____
 hernia _____
 appendix _____
 Renal / Bladder
 Bladder
 Pelvic (w/ transvaginal as indicated)
 Scrotum
 Thyroid
 Follow Up
 Reason:

Other:

- STAT**
 Patient to bring CD to doctor's office
 Call Report to Physician at:

 Physician's Direct Phone Number

MVA **WC** **DOI** _____

For us to obtain prior authorization please fax insurance card front and back

GENERAL INSTRUCTIONS

ULTRASOUND:

Gallbladder and/or Abdomen: Nothing to EAT or DRINK after midnight. Water is OK.

Pelvic: 1 hrs prior to exam, empty bladder (urinate). Start drinking 24 ounces of water. Finish water in 30 minutes. Do not empty bladder until exam is completed.

Renal: Drink 16 ounces of water 30 minutes prior to exam. Do not empty bladder prior to exam.

CT SCAN:

CT Exams Requiring IV Contrast: Nothing to EAT or DRINK 4 hours prior to exam.

CT Exams Requiring Oral Contrast: Nothing to EAT or DRINK 4 hours prior to exam. Patients may pick up oral contrast at the facility prior to the appointment or arrive 1 hour prior to the exam. Please confirm your selection when scheduling your appointment.

* **Note:** Some CT exams require both oral and IV contrast. In addition, some CT exams require lab work prior to your visit, please inquire when scheduling.

MRI:

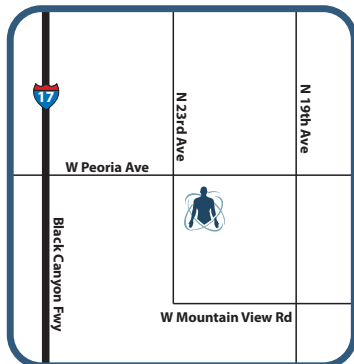
All MRI Exams: Notify office immediately if you have a **cardiac pacemaker, aneurysm clip, AICD (Cardiac Defibrillator), implanted device of any kind, or possible metal in your eye.**

MRI of the Abdomen: Nothing to Eat or Drink 4 hours prior to the exam.

* **Note:** Some MRI exams require lab work prior to your visit, please inquire when scheduling.

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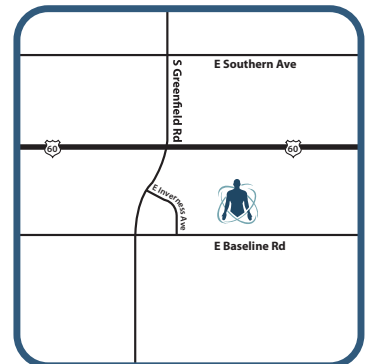
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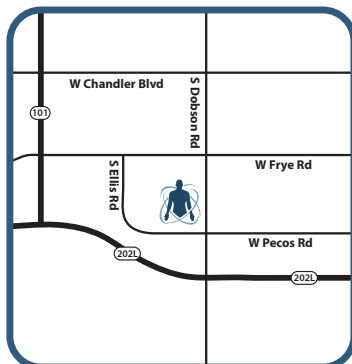
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