



AZ|TX
ADVANCED
IMAGING



Hablamos Español



SCHEDULING PHONE: 844-641-2111

EMAIL: SUPPORT@AZADVANCEDIMAGING.COM

- ☐ **Phoenix MRI, CT, US, X-RAY** - 2225 W Peoria Ave, Unit 150 Phoenix, AZ 85029
☐ **Scottsdale OPEN MRI ONLY** - 9787 N 91st St • Unit 101 Scottsdale, AZ 85258
☐ **Chandler MRI, CT, US, X-RAY** - 600 S Dobson Rd, Ste E42 Chandler, AZ 85224
☐ **Mesa MRI, CT, US, X-RAY** 4566 E Inverness Ave, Ste 102 Mesa, AZ 85206
☐ **Peoria OPEN MRI ONLY** - 6818 W. Thunderbird Rd Peoria, AZ 85381
☐ **Tucson MRI, X-RAY** 6261 N La Cholla Blvd, Ste 161 Tucson, AZ 85741
☐ **Tucson OPEN MRI, CT, US, X-RAY**, 3970 N. Campbell Ave Tucson, AZ 85719
☐ **Central Phoenix MRI, CT, US, X-RAY**, 444 W Osborn Road, Ste 105, Phoenix ,AZ 85013

P 602-753-4860 F 602-715-1510
P 480-927-3887 F 480-779-1370
P 480-306-7008 F 480-306-7316
P 480-308-7718 F 480-308-7717
P 602-753-4860 F 602-715-1510
P 520-783-2300 F 520-532-2026
P 520-210-0825 F 520-200-8358
P 602-362-3076 F 602-362-3185

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: _____
Case Manager: _____
Additional Report to: _____ ☐ MVA/PI ☐ Transportation Needed ☐ WC DOI _____ ☐ STAT
(Available for PI cases only)
Insurance carrier: _____ ID #: _____

MRI

(with reconstruction as indicated)

- ☐ Brain ☐ **TBI**
☐ Brain & IAC ☐ **SPINTECH**
☐ Brain & Pituitary ☐ **TBI Protocol**
☐ Only Pituitary ☐ **DTI**
☐ 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
☐ 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 reconstruction as indicated)

- ☐ Carotid Doppler
☐ Venous Doppler
upper extremity: Left _____ Right _____
lower extremity: Left _____ Right _____
☐ Abdominal Aorta
☐ Abdomen
☐ Abdomen Limited:
gallbladder _____
hernia _____
appendix _____
☐ Renal / Bladder
☐ Pelvic
☐ Scrotum
☐ Thyroid
☐ Follow Up

Reason: _____
☐ Other: _____

- ☐ Prior Imaging Report, CD
☐ Bring attorney's information or business card
☐ Personal and At-Fault (3rd Party Insurance Information)
☐ Police Report or Collision Exchange Form
☐ Call Report to Physician: _____

Physician's Direct Phone Number

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 6 hours prior to exam. Water is OK.

Pelvic: 1 hr 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.

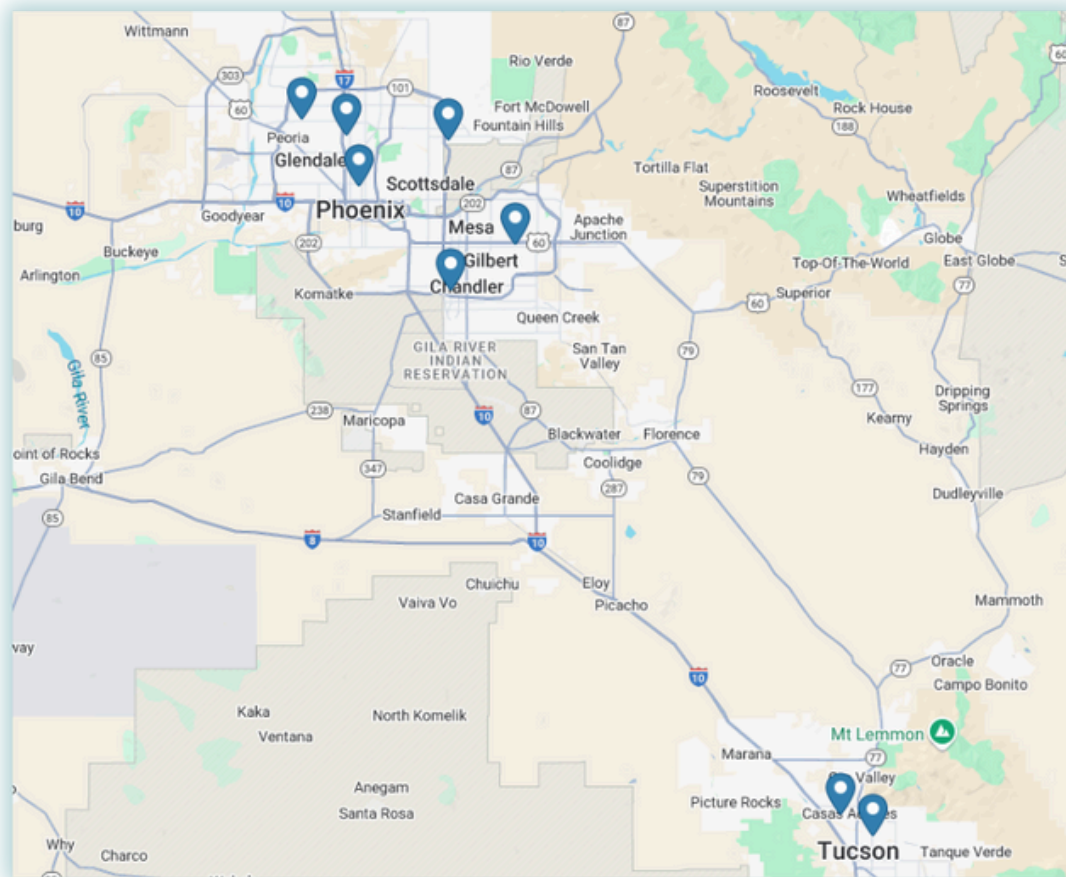
*** Some CT exams require both oral and IV contrast. In addition, some CT exams require lab work prior to your visit, please inquire when scheduling.

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.

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



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*****Phoenix Location: Open 7 Days a Week Mesa Location: Open 6 Days a Week**