Centralized Scheduling ◆ Ph 480 456 9000 ◆ F 480 632 1153 ◆ evdi.com

EVDI MEDICAL IMAGING

SDI southwest diagnostic imaging

Chandler	❑ 1076 W Chandler Blvd ♦ Suite 120 ♦ Chandler ♦ 480 393 3700
East Mesa	❑ 6424 E Broadway Rd ♦ Suite 101 ♦ Mesa ♦ 480 366 4700
Gilbert	❑ 665 N Gilbert Rd ♦ Suite 154 ♦ Gilbert ♦ 480 507 4500
Tempe	❑ 1840 E Warner Rd ♦ Suite 114 ♦ Tempe ♦ 480 768 2800

Professional Services by Associated Radiologists, Ltd ♦ Diplomates, American Board of Radiology

Please Present This Imaging Order at Time of Exam—See Maps and Preps on Back

Date_____

Name_____ DOB_____
(Last) (First)

SSN_____ Weight_____ Ph (H)_____ (W)_____

Referrer *(Please Print)*_____ Referrer Contact_____ Contact Ph_____

Send Copies To_____ _____ _____

Scheduling Instructions

❑ Schedule Appointment ASAP
❑ Please Call Patient to Schedule Exam
❑ Please Obtain Auth *Include Patient PHI, H & P and Insurance Card*

Ins. Preauth. #: _____

Appointment Details

Appt Date: _____
Appt Time: _____
Arrival Time: _____

Report/Image Instructions

❑ Fax Report to ( ) _____
❑ Call STAT to ( ) _____
❑ Films ❑ CD with Patient
❑ Films ❑ CD with Report
to Location _____

MUSCULOSKELETAL RADIOLOGY ORDER

MRI *(x-rays, if indicated)*

❑ **3T** ❑ **1.5T** ❑ **Open**

Contrast
❑With ❑Without
❑With & Without
❑Per Radiologist

❑ Brachial Plexus R L B
❑ Clavicle R L B
❑ Extremity - Non-Joint R L B
- ❑ Calf ❑ Hand
- ❑ Fingers ❑ Thigh
- ❑ Foot ❑ Upper Arm
- ❑ Forearm

❑ Extremity - Joint R L B
- ❑ Ankle ❑ Knee
- ❑ Elbow ❑ Shoulder
- ❑ Hip ❑ Wrist ❑ Arthrogram
- ❑ Cartilage Sequences/T2 Mapping

❑ Spine C T L
❑ MRA Lower Extremity R L B
❑ MRA Upper Extremity R L B
❑ Other: _____

Nuclear Medicine

(flow study/SPECT/x-rays, if indicated)

❑ Bone Scan
- ❑ Total Body
- ❑ 3 Phase
- ❑ Limited _____

CT *(3D if indicated)*

❑ Extremity R L B

Contrast
❑With ❑Without
❑With & Without
❑Per Radiologist

- ❑ Calf ❑ Ankle
- ❑ Fingers ❑ Hip
- ❑ Foot ❑ Knee
- ❑ Forearm ❑ Shoulder
- ❑ Hand ❑ Wrist
- ❑ Thigh
- ❑ Upper Arm ❑ Arthrogram
- ❑ Extremity CTA

❑ Pelvis ❑ Pelvis CTA ❑ Bony Pelvis
❑ Neck - Soft Tissue
❑ Spine C T L
❑ Other: _____

X-ray

❑ Ankle R L B
❑ Chest
❑ Foot R L B
❑ Hand R L B
❑ Hip R L B
❑ Knee R L B
❑ Pelvis AP
❑ Shoulder R L B
❑ Spine 2-V/3-V C T L
❑ Spine 5-V C T L
❑ Other: _____

Ultrasound *(Doppler, if indicated)*

❑ Venous Arm R L B
❑ Venous Leg R L B
❑ Other: _____

DXA

❑ DXA Scan (Bone Densitometry)

Clinical History/ICD-10 Code(s)

_____
_____
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*Complete This Section When Ordering CT

Does the patient have both functioning kidneys? ❑ Yes ❑ No
Creatinine _____ (Not Ratio) on DATE: _____

Is the Patient Allergic to Iodine? ❑ Yes ❑ No
Is the Patient Diabetic? ❑ Yes ❑ No