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





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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 DOB (First) _____ Ph (H)______ (W)_____ SSN ____ Weight____ Referrer Contact______ Contact Ph____ Referrer (Please Print)____ Send Copies To **Report/Image Instructions Scheduling Instructions Appointment Details** ☐ Fax Report to (☐ Schedule Appointment ASAP Appt Date: ☐ Please Call Patient to Schedule Exam ☐ Call STAT to (Appt Time: ___ ☐ Please Obtain Auth Include Patient PHI, H & P ☐ Films ☐ CD with Patient Arrival Time: ____ and Insurance Card ☐ Films ☐ CD with Report to Location Ins. Preauth. #: __ Clinical History/ICD-10 Code(s) **Exam Requested** (3D. if indicated) CTA^* MRI (x-rays, if indicated) 3T MRI Open MRI □ Arthrogram □ Cartilage Sequences/T2 Mapping □ CSF Flow Study □ Spectroscopy □ Perfusion MRA (Angiography)_ **Ultrasound** (transvaginal/Doppler, if indicated) **Nuclear Medicine** (flow study/SPECT/x-rays, if indicated) PET/CT Scan _____ Fluoroscopy/IVP* ☐ Esophagram ☐ UGI ☐ SBFT ☐ BE ☐ BE with Air ☐ Non-Tomo IVP* **Bone Densitometry (DXA)** □

*Complete This Section When Ordering CT or IVP

Does the patient have	both functioning kidneys? ☐ Yes ☐ No	Is the Patient Allergic to Iodine?	☐ Yes ☐ No
Creatinine	(Not Ratio) on DATE:	Is the Patient Diabetic?	☐ Yes ☐ No