Imaging Order Form

If authorization needed copy front and back of insurance card and appropriate physician notes

Today's Date

EAST VALLEY ER & HOSPITAL
5656 S Power Rd Gilbert AZ 85295
(602) 830-4911

PHOENIX ER
3050 S Dobson Rd Chandler AZ 85248
(480) 284-5867

PATIENT INFORMATION DOB _____ Weight _____ lb

Last Name _____ First Name _____

Primary Phone # _____ Preferred Language ☐ English ☐ Other

Insurance Company _____ Authorization # _____ Date Range _____

REFERRAL PHYSICIAN INFORMATION NPI # _____

Name _____ Signature _____

Phone # _____ Email _____

Was the patient prescribed medication for claustrophobia?

Clinical Hx/Dx for exam (include ICD 10 codes)

BILLING TYPE ☐ Cash ☐ Medical Insurance ☐ Personal Injury (no contract) ☐ Workmans Compensation (include adjudicator and claim info)

☐ Personal Injury (Contract) **CONTRACT COMPANY NAME:**

XRAY

☐ Chest 2V
☐ KUB Abdomen
☐ Pelvis
☐ Ribs +Chest ☐ R ☐ L ☐ Bil
☐ Shoulder ☐ R ☐ L ☐ Bil
☐ Elbow ☐ R ☐ L ☐ Bil
☐ Wrist ☐ R ☐ L ☐ Bil
☐ Hand ☐ R ☐ L ☐ Bil
☐ Hip ☐ R ☐ L ☐ Bil
☐ Knee ☐ R ☐ L ☐ Bil
☐ Ankle ☐ R ☐ L ☐ Bil
☐ Foot ☐ R ☐ L ☐ Bil
☐ Spine ☐ C ☐ T ☐ L
☐ Obliques ☐ Flex/Ext
☐ Other specify _____

☐ Skull
☐ Orbits
☐ Sinuses

CT

☐ Oral Contrast
☐ IV contrast
☐ W/O contrast
☐ With and Without

☐ Head/Brain ☐ Chest
☐ Neck ☐ Abdomen only
☐ Sinus ☐ Pelvis only
☐ Orbits ☐ Abdomen/Pelvis

☐ Extremity ☐ Upper ☐ Lower
☐ R ☐ L ☐ Bil

☐ CTA
☐ Head/Brain
☐ Neck
☐ Chest PE
☐ Abdomen/Pelvis
☐ Aorta check all that apply
☐ Thoracic ☐ Abdominal ☐ Ileofemoral runoff

☐ Joint specify _____

☐ Spine ☐ C ☐ T ☐ L

ULTRASOUND

☐ Abdomen Complete ☐ Gallbladder
☐ Abdomen Ltd specify _____
☐ Pelvis TV
☐ Bladder ☐ Testicular/Scrotum
☐ Aorta ☐ Renal
☐ Thyroid ☐ Carotid

☐ Venous ☐ Arterial
☐ Lower Ext ☐ R ☐ L ☐ Bil
☐ Upper Ext ☐ R ☐ L ☐ Bil

☐ OB/TV 1st trimester
☐ OB 2nd trimester
☐ OB 3rd trimester
☐ OB Limited specify _____
☐ Soft Tissue specify _____

MRI

☐ IV contrast
☐ W/O contrast
☐ With and Without

☐ Head/Brain
☐ Neck
☐ Auditory Canal
☐ Orbits
☐ Abdomen only
☐ Pelvis only
☐ MRCP

☐ Shoulder ☐ R ☐ L ☐ Bil
☐ Elbow ☐ R ☐ L ☐ Bil
☐ Wrist ☐ R ☐ L ☐ Bil
☐ Chest ☐ R ☐ L ☐ Bil
☐ Hip ☐ R ☐ L ☐ Bil
☐ Knee ☐ R ☐ L ☐ Bil
☐ Ankle ☐ R ☐ L ☐ Bil
☐ Foot ☐ R ☐ L ☐ Bil
☐ Spine ☐ C ☐ T ☐ L
☐ Joint other _____

☐ MRA (w/o contrast only)
☐ Head/Brain
☐ Neck

☐ MRV (w/o contrast only)
☐ Carotids
☐ Abdomen/Pelvis

Submit Form via FAX to (602) 830-4912 or via EMAIL to RegFax@EastValleyHospital.com