Valleywise Health

SCHEDULING AND PRIOR AUTH:
PHONE: 602-344-1300 FAX: 602-655-9230

When Faxing include: Demographics, Insurance Card, Prior Imaging and Labs

TODAY'S DATE:

☐ Obtain Prior Auth

☐ URGENT ☐ STAT ☐ ROUTINE

PATIENT NAME (Please Print) (Required):

HOME PHONE #: | CELL PHONE #: | PATIENT DOB:

INSURANCE: | INSURANCE ID / GROUP #:

REASON FOR PROCEDURE: CLINICAL FINDINGS/SYMPTOMS (NO R/O's, possibles, evaluates, ICD 10 Codes):

☐ PATIENT HAND CARRY CD OR ☐ MAIL CD IMAGES TO:

PHYSICIAN/PROVIDER NAME (Printed): | PHYSICIAN/PROVIDER SIGNATURE: | REFERRING PHYSICIAN PHONE: | REFERRING PHYSICIAN FAX:

* May require preparation ^ Lab work may be required + May require H&P ! General studies only

☐ WITH CONTRAST ☐ WITHOUT CONTRAST ☐ Per Radiologist's Discretion

H & P within 30 days of scheduled appointment

☐ IV SEDATION ☐ GENERAL ANESTHESIA ☐ DIFFICULT AIRWAY

☐ CT ☐ CTA ! (650LB)

☐ ABD*^ ☐ T-SPINE ☐ CHEST
☐ PELVIS*^+ ☐ L-SPINE ☐ SOFT TISSUE NECK
☐ BRAIN*^ ☐ C-SPINE ☐ SINUS ☐ CCTA
☐ UPPER EXTREMITY ☐ HEAD ☐ NECK
☐ LOWER EXTREMITY
☐ CT BIOPSY OF*^+ Send tissue to pathology and cytology
☐ OTHER

☐ ULTRASOUND/VASCULAR !

☐ VEIN MAPPING* ☐ TRANSVAGINAL
☐ ABDOMEN COMPLETE* ☐ RENAL ☐ PYLORIC
☐ ABDOMEN DUPLEX* ☐ RENAL ARTERY*
☐ SOFT TISSUE ☐ THYROID
☐ OB ☐ >14 WEEKS ☐ <14 WEEKS ☐ PELVIS*
☐ CAROTID DOPPLER ☐ GRAFT SURVEILLANCE*
☐ PARACENTESIS*^+ ☐ HEAD ☐ NECK
☐ TRANSCRANIAL DOPPLER ☐ HIP ☐ SCROTAL
☐ LOWER EXTREMITY ☐ R ☐ L ☐ BILAT
☐ UPPER EXTREMITY ☐ R ☐ L ☐ BILAT
☐ ARTERIAL DUPLEX LOWER ☐ R ☐ L ☐ BILAT
☐ ARTERIAL DUPLEX UPPER ☐ R ☐ L ☐ BILAT
☐ THORACENTESIS W/CXR IF NEEDED^+
☐ ULT BIOPSY OF*^+ Send tissue to pathology and cytology
☐ OTHER _____

☐ Women's Center

☐ MAMMO SCREENING ☐ 3D ☐ BREAST MRI
☐ DIAGNOSTIC ☐ DEXA
☐ BIOPSY ☐ LEFT ☐ RIGHT
☐ NEEDLE LOCALIZATION ☐ LEFT ☐ RIGHT
☐ SENTINEL LYMPH NODE INJECTION
☐ OTHER

☐ MRI ☐ MRA (550LB)

☐ Brain ☐ C-Spine ☐ L-Spine ☐ T-Spine
☐ Abdomen* ☐ MRCP* ☐ Pelvis
☐ IAC ☐ Neck ☐ HEAD ☐ Chest
☐ MRI ARTHROGRAM OF:
☐ EXTREMITY UPPER
☐ EXTREMITY LOWER
☐ OTHER

☐ NUCLEAR MEDICINE (500LB)

THYROID NM EXAMS REQUIRES LABS

☐ BIPHASE RENAL* ☐ VASOTEC ☐ DIURESIS (lasix)
☐ THYROID THERAPY* ☐ THYROID UPTAKE & SCAN*
☐ THYROID WHOLE BODY*^ ☐ PARATHYROID SCAN
☐ THYROGEN 0.9MG IM Q24hrs X 2 doses
☐ HEPATOBILIARY SCAN (HIDA / DISIDA)* ☐ EJECTION FRACTION
☐ SINGLE PHASE GASTRIC EMPTYING*
☐ V/Q LUNG SCAN
BONE SCAN (Mark one) ☐ 3 PHASE ☐ LIMITED ☐ WHOLE BODY
WBC SCAN (Mark one) ☐ 3 PHASE ☐ LIMITED ☐ WHOLE BODY
☐ BONE MARROW SCAN ☐ MIBG ☐ DaTSCAN*
☐ BONE PALLIATION (SAMARIUM)(Sm53) ☐ MUGA
☐ SENTINEL LYMPH NODE INJECTION ☐ OCTREOSCAN*
NUCLEAR STRESS TEST* (Mark one)
☐ LEXISCAN ☐ DOBUTAMINE ☐ TREADMILL
☐ OTHER _____

☐ *Echo*

☐ STRESS ECHO ☐ TEE ☐ Echo

☐ PET/CT (400LB)

☐ Skull to Thighs (dx: _____)
☐ WHOLE BODY (dx: _____)

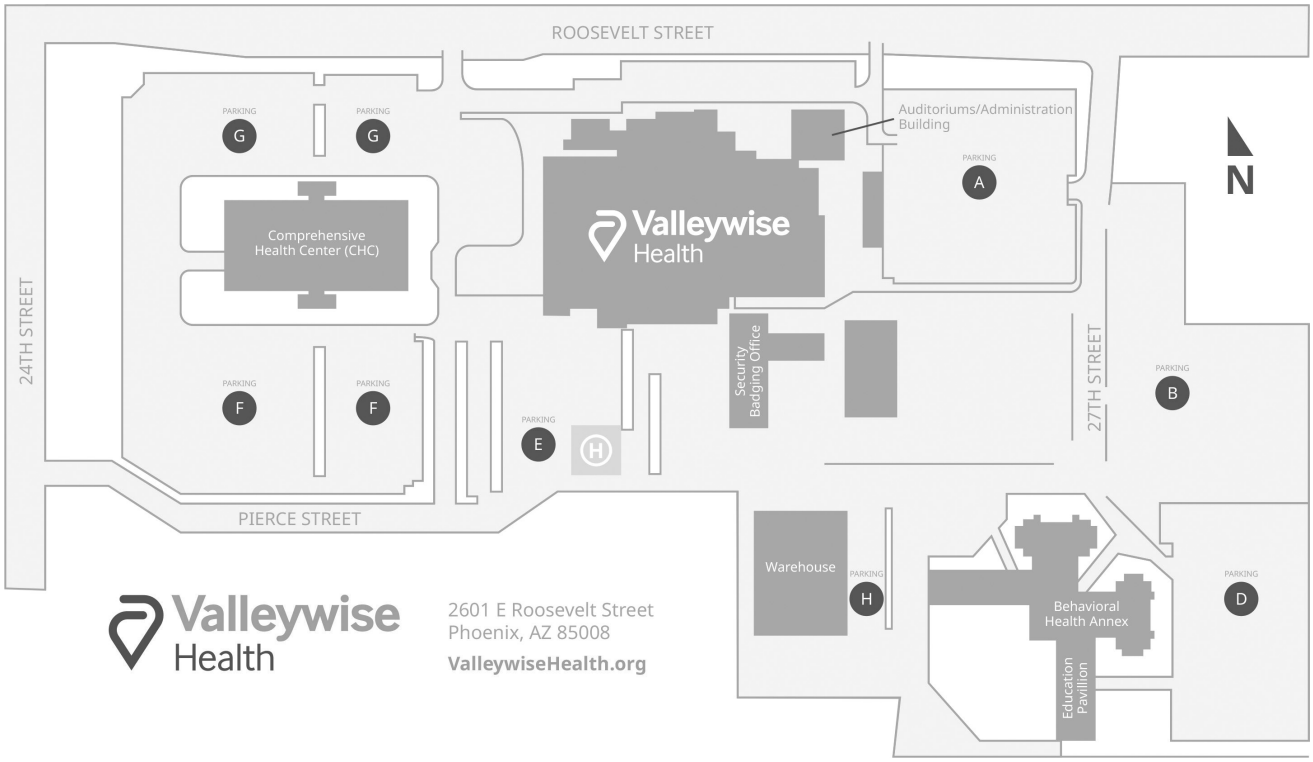
☐ X-Ray ! (500LB)

☐ CHEST ☐ 2 VIEW ☐ 1 VIEW
☐ KUB (ABDOMEN) ☐ ABDOMEN 2 VIEWS
☐ PELVIS ☐ SKULL ☐ SPINE VIEW
☐ SHOULDER ☐ LEFT ☐ RIGHT
☐ ELBOW ☐ LEFT ☐ RIGHT
☐ WRIST ☐ LEFT ☐ RIGHT
☐ HAND ☐ LEFT ☐ RIGHT
☐ HIP ☐ LEFT ☐ RIGHT
☐ KNEE ☐ LEFT ☐ RIGHT
☐ ANKLE ☐ LEFT ☐ RIGHT
☐ FOOT ☐ LEFT ☐ RIGHT
☐ SINUS VIEW ☐ OTHER

☐ FLUOROSCOPY (660LB)

☐ LUMBAR PUNCTURE^+
☐ ARTHROGRAM^ _____
☐ SMALL BOWEL F/T*
☐ HYSTEROSALPINGOGRAPHY
☐ CYSTOGRAM
☐ ESOPHAGRAM*
☐ MODIFIED BARIUM SWALLOW*
☐ BARIUM ENEMA* ☐ W/AIR ☐ W/O AIR
☐ MYELOGRAM OF*^+_____
☐ UGI*
☐ VCUG
☐ OTHER _____
_____
_____

MEDICAL IMAGING OUTPATIENT SCHEDULING



1. **Valleywise Health Medical Center**
   2601 E Roosevelt St
   Phoenix, AZ 85008
   602.344.5011
   Located east of the CHC, 1st floor, Radiology Dept.
   - X-ray
   - MRI
   - Ultrasound
   - IR
   - CT Scan
   - Nuclear Med
   - Echocardiogram
   - Cardiac Cath

2. **Valleywise Health Comprehensive Center - Peoria**
   8088 W Whitney Dr
   Peoria, AZ 85345
   - X-ray
   - MRI
   - Ultrasound
   - CT Scan
   - Echocardiogram
   - Mammography

3. **Valleywise Health Comprehensive Center - Phoenix**
   2525 E Roosevelt, 3rd floor
   Phoenix, AZ 85008
   602.344.5011
   - X-ray
   - Mammography
   - Ultrasound
   - Dexa/Bone Density

4. **Valleywise Health Medical Center Maryvale**
   5102 W Campbell Ave
   Phoenix, AZ 85031
   - X-ray
   - CT Scan
   - Ultrasound

5. **Valleywise Health Community Health Center - Avondale**
   950 E Van Buren St
   Avondale, AZ 85323
   623.344.6800
   - X-ray
   - Mammography
   - Ultrasound

6. **Valleywise Health Community Health Center - Chandler**
   811 W Hamilton
   Chandler, AZ 85225
   480.344.6100
   - X-ray
   - Ultrasound

7. **Valleywise Health Community Center - South Phoenix/ Laveen**
   5650 S 35th Ave
   Phoenix, AZ 85041
   602.655.6400
   - Ultrasound
   - X-ray

8. **Valleywise Health Community Center - North Phoenix**
   2025 W Northern Ave
   Phoenix, AZ 85021
   602.655.6300
   - X-ray
   - Ultrasound

9. **Valleywise Health Community Health Center - Mesa**
   59 S Hibbert
   Mesa, AZ 85210
   480.344.6200
   - Ultrasound