Valleywise Health

MEDICAL IMAGING REFERRAL

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

Fax: 602-655-9230 PHONE: 602-344-1300 ☐ **URGENT** ☐ **STAT** ☐**ROUTINE**

TODAY'S DATE:	ORDERING CLINIC'S NAME:
CLINIC ADDRESS:	
PHYSICIAN/PROVIDER NAME (PRINTED):	
PHYSICIAN/PROVIDER SIGNATURE:	
If Physician Assistant, Authorizing Provider:	
REFFERING PHYSICIAN PHONE:	REFFERING PHYSICIAN FAX:

Patient Demographic Information

PATIENT NAME:	DOB:	
PARENT/GUARDIAN NAME:	RELATIONSHIP:	
HOME ADDRESS:	CELL PHONE #:	
INSURANCE:	INSURANCE ID#:	GROUP #:

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

DIAGNOSIS (DESCRIPTION):	DIAGNOSIS CODE:	
☐ 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	☐ NEC
☐ 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	
☐ CAROTID DOPPLER	☐ SCROTOL	
☐ OB ☐ >14 WEEKS ☐ <14 WEEKS	☐ GRAFT SURVEILLANCE*	
☐ PARACENTESIS*^+	☐ HEAD	☐ NECK
☐ TRANSCRANIAL DOPPLER	☐ HIP	☐ PELVIS
☐ LOWER EXTREMITY	☐ R ☐ L ☐ BILAT	
☐ UPPER EXTREMITY	☐ R ☐ L ☐ BILAT	
☐ ARTERIAL DUPLEX LOWER	☐ R ☐ L ☐ BILAT	
☐ ARTERIAL DUPLEX UPPER	☐ R ☐ L ☐ BILAT	
☐ ARTERIAL DUPLEX UPPER ☐ R ☐ L ☐ BILAT ☐ 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	☐ LEFT	☐ RIGHT
☐ OTHER _____		

☐ MRI ☐ MRA (550LB)

☐ Brain	☐ C-Spine	☐ L-Spine	☐ T-Spine
☐ Abdomen*		☐ MRCP*	☐ Pelvis
☐ IAC	☐ Neck	☐ HEAD	☐ Chest
☐ RI 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		
☐ 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 (400LBS)

☐ SKULL TO THIGHS (dx: _____)	☐ SODIUM FLUORIDE BONE (dx: _____)
☐ WHOLE BODY (dx: _____)	☐ OTHER _____
☐ COMMENTS: _____	

☐ 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
☐ WRIST	☐ 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 ☐ VCUH
☐ OTHER