Arizona Advanced Imaging

Phoenix
MRI, CT, US, X-RAY
2225 W Peoria Ave, Unit 150
Phoenix, AZ 85029
PH **602-753-4860**
F **602-715-1510**

Scottsdale
OPEN MRI ONLY
9787 N 91st St • Unit 101
Scottsdale, AZ 85258
PH **480-927-3887**
F **480-779-1370**

Mesa
MRI, CT, US, X-RAY
4566 E Inverness Ave, Ste 102
Mesa, AZ 85206
PH **480-308-7718**
F **480-308-7717**

Chandler
MRI, CT, US, X-RAY
600 S Dobson Rd, Ste E42
Chandler, AZ 85224
PH **480-306-7008**
F **480-306-7316**

Peoria
OPEN MRI ONLY
6818 W. Thunderbird Rd, Ste 5025
Peoria, AZ 85381
PH **602-753-4860**
F **602-715-1510**

Tucson
MRI, X-RAY
6261 N La Cholla Blvd, Ste 161
Tucson, AZ 85741
PH **520-783-2300**
F **520-532-2026**

Please bring this completed order, your insurance card, and a photo ID with you to your appointment.

Today's date: ____________ Appointment date: ____________ Appointment time: ____________

Patient Name: ____________ *(last)* ____________ *(first)* DOB: ___/___/_____ *MM DD YYYY* ☐ M or ☐ F Patient Phone: ____________

Diagnosis/Current Symptoms/History: ____________ ICD 10 Code: ____________

Physician Signature: ____________ Phone: ____________ Fax: ____________

Print Physician Name: ____________

Attorney Name: ____________ Phone: ____________ Fax: ____________

Insurance carrier: ____________ ID #: ____________

MRI
(with reconstruction as indicated)

- ☐ Brain
- ☐ Brain & IAC
- ☐ Brain & Pituitary
- ☐ IAC Only
- ☐ Pituitary Only
- ☐ Orbits
- ☐ Neck Soft Tissue
- ☐ Spine:
  - cervical ____
  - thoracic ____
  - lumbar ____
- ☐ SWI
- ☐ TBI
- ☐ DTI
- ☐ ALAR
- ☐ Abdomen (indicate area of interest below)

____

- ☐ MRCP
- ☐ Adrenals
- ☐ Pelvis
- ☐ Extremity: left ____ right ____
  - body part: ____________
- ☐ **Other:**

____

- ☐ **Without contrast**
- ☐ **With & without contrast**

MR Angiography (MRA)

- ☐ Brain
- ☐ Neck - Carotids
- ☐ Chest
- ☐ Renals
- ☐ **Other:**

____

- ☐ **Without contrast**
- ☐ **With & without contrast**

CT
(with reconstruction as indicated)

- ☐ Head / Brain
- ☐ Temporal Bones (IAC's)
- ☐ Sinus (Maxillofacial)
  - complete ____ limited ____
- ☐ Maxillofacial – Facial Bones
- ☐ Neck Soft Tissue
- ☐ Shoulder: left ____ right ____
- ☐ Spine:
  - cervical ____
  - thoracic ____
  - lumbar ____
- ☐ Chest
- ☐ Abdomen (pelvis as indicated)
- ☐ Pelvis
- ☐ CT Urogram
- ☐ CT Stone Protocol
- ☐ Hip: left ____ right ____
- ☐ Extremity: left ____ right ____
  - Indicate area of interest: ____________
- ☐ **Other:**

____

- ☐ **With contrast**
- ☐ **Without contrast**
- ☐ **With & without contrast**

CT Angiography *(w & w/o contrast)*

- ☐ Head / Brain
- ☐ Neck - Carotids
- ☐ Chest
- ☐ Abdomen (pelvis as indicated)
- ☐ Pelvis
- ☐ **Other:**

____

X-RAY

- ☐ Skull
- ☐ Orbits
- ☐ Sinuses:
  - waters ____
  - limited ____
  - complete ____
- ☐ Shoulder: left ____ right ____
- ☐ Neck Soft Tissue
- ☐ Chest: PA ____ PA/LAT ____
- ☐ Ribs (w/ PA Chest):
  - left ____ right ____
- ☐ Spine: ☐ Add Flex/Ext
  - cervical ____
  - thoracic ____
  - lumbar ____
- ☐ KUB
- ☐ Acute Abdominal Series
- ☐ Hip: left ____ right ____
- ☐ Bilateral Hips (w/ pelvis)
- ☐ Pelvis
  - Indicate area of interest: ____________
- ☐ **Extremity:** left ____ right ____
- ☐ **Other:**

____

ULTRASOUND
(with Doppler as indicated)

- ☐ Carotid Doppler
- ☐ Venous Doppler
  - upper extremity: left ___ right ___
  - lower extremity: left ___ right ___
- ☐ Abdominal Aorta
- ☐ Abdomen
- ☐ Abdomen Limited:
  - gallbladder ____
  - hernia ____
  - appendix ____
- ☐ Renal / Bladder
- ☐ Bladder
- ☐ Pelvic (w/ transvaginal as indicated)
- ☐ Scrotum
- ☐ Thyroid
- ☐ Follow Up

Reason:

____

- ☐ **Other:**

____

- ☐ **STAT**
- ☐ Patient to bring CD to doctor's office
- ☐ Call Report to Physician at:

____
Physician's Direct Phone Number

☐ **MVA** ☐ **WC** **DOI** ____________

For us to obtain prior authorization please fax insurance card front and back