# Arizona Advanced Imaging

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website: azadvancedimaging.com

Patient Name: _____ D.O.B.: _____ AGE: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance: _____ Auth #: _____ Claim #: _____

❑ MVA ❑ Transportation Needed ❑ Notes Attached ❑ Labs Attached ❑ Insurance Card Attached

Attorney Name: _____ Phone: _____

## EXAM INFO

❑ MRI
❑ MRA
❑ CT
❑ CTA

Exam Needed: _____

Diagnosis: _____ ❑ STAT Request ICD-10 _____

❑ Without Contrast
❑ With and Without Contrast
❑ Radiologist Discretion

## ULTRASOUND

Exam Needed: _____

Diagnosis: _____

❑ STAT Request ICD-10 _____

## GENERAL X-RAY

Exam Needed: _____

Diagnosis: _____

❑ STAT Request ICD-10 _____

## PHYSICIAN INFORMATION

Referring Physician Name: _____

Signature: _____
May modify exam at radiologist discretion if clinically indicated

Signature: _____
Scan as ordered

Referral Coordinator: _____ Phone: _____ Fax: _____

## REPORT INFORMATION

Next Appointment On: _____

❑ CC Report to Fax # _____

❑ Hand Carry CD ❑ Deliver CD Today's Date: _____

## STAT REQUEST

❑ Fax _____ ❑ Call _____

## APPOINTMENT INFORMATION

❑ Please call and schedule patient ❑ Patient has already been scheduled Date: _____ Time: _____