

Patient Information

Patient Name: _____ Phone: _____
 Exam Date: _____ Arrival Time: _____ D.O.B. _____
 Insurance: _____ Exam Time: _____
 Pre-Authorization # _____

Clinician Information

Clinician: _____ Phone # _____ Fax # _____
 YES NO Relevant previous imaging studies? If YES Office will send Patient will bring

Scheduling Information

Patient will call to schedule Please call patient to schedule Patient phone # _____
Report Handling Mail Fax Call report Physician phone _____ Fax report Physician fax # _____
 CD with Patient Delivered Film with Patient Delivered

Exam

Name of Exam	Exam Procedure	Reason for Exam / ICD-9 Code Signs and Symptoms
MRI – Magnetic Resonance Imaging Does the radiologist have authorization to perform additional procedures if indicated by ordered exam? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Brain MRI <input type="checkbox"/> Brain MRA Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Joint (specify): _____ <input type="checkbox"/> Extremity (specify): _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Radiologist Decides <input type="checkbox"/> with Contrast <input type="checkbox"/> w/o Contrast	
CT – Computed Tomography Does the radiologist have authorization to perform additional procedures if indicated by ordered exam? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Brain <input type="checkbox"/> Sinus <input type="checkbox"/> Chest <input type="checkbox"/> Extremity (specify): _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Radiologist Decides <input type="checkbox"/> with Contrast <input type="checkbox"/> w/o Contrast	
Breast Imaging Does the radiologist have authorization to perform additional procedures if indicated by ordered exam? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Diagnostic Mammogram <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Breast MRI <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> right <input type="checkbox"/> left	
Ultrasound Does the radiologist have authorization to perform additional procedures if indicated by ordered exam? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Abdomen <input type="checkbox"/> Breast <input type="checkbox"/> OB <input type="checkbox"/> Pelvis <input type="checkbox"/> Testicular <input type="checkbox"/> Pelvis w/TV <input type="checkbox"/> Thyroid <input type="checkbox"/> Renal <input type="checkbox"/> Other (specify): _____	
Vascular Lab	<input type="checkbox"/> Duplex Scan: <input type="checkbox"/> Venous <input type="checkbox"/> Arterial <input type="checkbox"/> Carotid	
X-Ray	<input type="checkbox"/> CXR (PA/lateral) <input type="checkbox"/> Extremities(specify) _____ <input type="checkbox"/> Shoulder <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Other (specify): _____	

Some diagnostic imaging exams require prior preparations. Please check the back of this form for specific instructions.

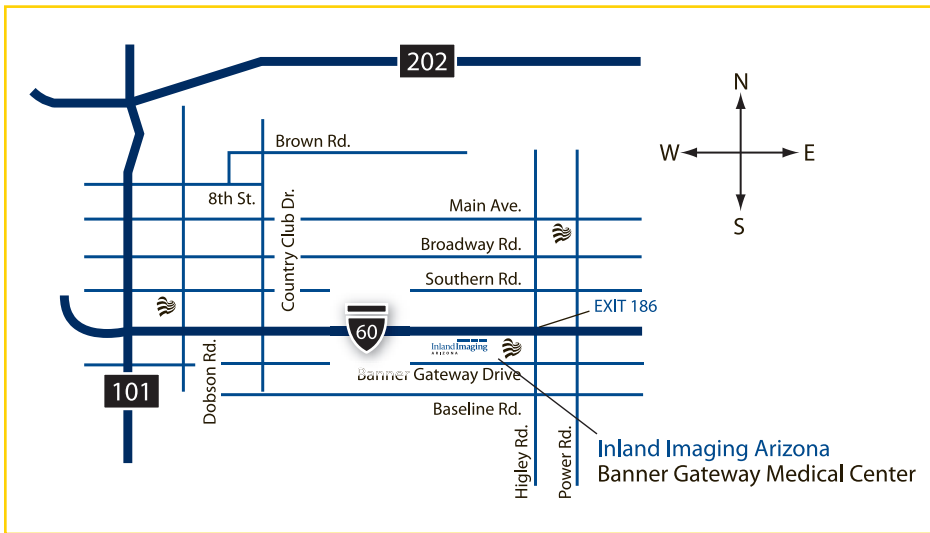
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Inland Imaging

A R I Z O N A

Patient Preparation

MRI – Magnetic Resonance Imaging	Are you claustrophobic? Do you have a pacemaker? If so, please contact the center for instructions. Metal objects are not allowed in the scanner. Please refrain from wearing metal objects such as jewelry, watches and bobby pins.
CT – Computed Tomography	Center will provide detailed information.
Mammography	Wear two-piece clothing. Do not wear powder, deodorant or lotion in the breast area.
Ultrasound Procedures	<input type="checkbox"/> Abdomen Nothing by mouth 6-8 hours prior to exam. <input type="checkbox"/> Pelvis or OB Drink 32 ounces of water one hour prior to exam. Do not empty bladder until the examination is completed. <input type="checkbox"/> Renal Drink plenty of liquids.
DEXA Scan w/Vertebral Assessment	No preparation.
If you are unsure of prior preparation requirements please call the center for further instructions.	



Inland Imaging Arizona
 2940 East Banner Gateway Drive
 Suite 150
 Gilbert, AZ 85234
www.inlandimagingAZ.com

Scheduling
480.543.6900

Directions:
 Take **US-60** to Higley Rd exit (EXIT 186).
 Go South on Higley Rd to Banner Gateway Drive.
 Turn West on Banner Gateway Drive and turn into the Canyon Springs Medical Plaza patient parking area.
 Inland Imaging is located on the first floor, directly West of Banner Gateway Medical Center.

