Imaging Referral Form

PATIENT INFORMATION:

Please bring this form with you to your appointment

Parent/Guardian Name ______________________________________________________________________________________

Child’s Name______________________________________________________Date of Birth_____________________

Day Phone________________________________Evening Phone____________________________Today’s Date____________

Insurance____________________________________________________________Authorization #________________________

Referring Physician________________________________________Referring Physician Phone #________________________

Referring Physician Fax # _____________________Contact person from Doctor’s office________________________________

Patient’s weight_____________________________

 Male   Female  Language Spoken______________________________

LOCATIONS:

 Phoenix Children’s Hospital
  1919 E. Thomas Rd.
  Phoenix, AZ 85016

 Phoenix Children’s Specialty and Urgent Care
  East Valley Center
  5131 E. Southern Ave.
  Mesa, AZ 85206

 Phoenix Children’s Specialty and Urgent Care
  Northwest Valley Center
  20325 N. 51st Ave., Suite 116
  Phoenix, AZ 85308
  (X-ray only at this location)

EXAM REQUESTED

X-RAY (Please be specific)

☐ Chest (1 view)
☐ Chest (2 views)
☐ Sinus - view
☐ Skull - view
☐ Neck (soft tissue)
☐ Spine - view
☐ Scoliosis
☐ Upper Extremity view/side (specify below)
☐ Lower Extremity view/side (specify below)
☐ Extremity view/side
☐ Other –
☐ Barium Enema (BE)***
☐ Upper GI (UGI)***
☐ UG/Small Bowel***
☐ Voiding Cystourethrogram (VCUG)***
☐ Modified Barium Swallow (with speech)”***
☐ DEXA***
☐ Other
☐ Other Non-radiology Outpatient Tests Ordered

ULTRASOUND

☐ Head***
☐ Renal (Kidney)***
☐ Abdomen (Complete or Limited)***
☐ Pelvis***
☐ Hip***
☐ Pyloric***
☐ Testicular/Pelvic Doppler***
☐ Other***

NUCLEAR MEDICINE*

☐ Bone Scan (Whole Body)***
☐ GFR***
☐ MAG-3***
☐ Gastric Emptying (Liquid or Solids)***
☐ DMSA***
☐ Other***

CT

Contrast (specify)
☐ w/cont  ☐ w/o  ☐ w & w/o

Sedate (specify)
☐ with  ☐ w/o  ☐ general

☐ Sinus***
☐ Head***
☐ Chest***
☐ Abdomen/Pelvis***
☐ Pelvis***
☐ Other (specify)***

MRI

Contrast (specify)
☐ w/o  ☐ w & w/o

Anesthesia (specify)
☐ with  ☐ w/o  ☐ general

☐ Head***
☐ Spine (specify below)***
☐ Other (specify below)***

CT PET (FD6)

☐ Whole Body
☐ Eyes to Thighs
☐ Brain
☐ C11 Brain

SPECIAL NEEDS:

HISTORY:

☐ Check here if additional clinical information is included with this order

PHYSICIANS/PA/NP SIGNATURE:______________________________________________________________
PHOENIX CHILDREN’S HOSPITAL-MAIN CAMPUS

Main Campus
1919 E. Thomas Rd.
Phoenix, AZ 85016

For Imaging appointments please park in Thomas Garage West and check-in at the front desk of the Main Building before proceeding to the Imaging Check-in

PHOENIX CHILDREN’S SPECIALTY AND URGENT CARE

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Mesa, AZ 85206

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