DVR
DESERT VALLEY RADIOLOGY

Tax ID # 86-0467926
www.dvrphx.com

❑ **Phoenix North Location**
4045 E. Bell Rd., Ste. 143
Phoenix, AZ 85032
Main: **602-867-0404**
Fax: **602-788-0893**

❑ **Tempe/Chandler/Ahwatukee**
8380 S. Kyrene Rd., Ste. 105
Tempe, AZ 85284
Main: **480-785-2511**
Fax: **480-705-4431**

❑ **Mesa Location**
5424 E. Southern Ave., Ste. 104
Mesa, AZ 85206
Main: **480-776-5340**
Fax: **480-776-5344**

❑ **Paradise Valley Location**
11209 N. Tatum, Ste. 180
Phoenix, AZ 85028
Main: **602-765-8290**
Fax: **602-765-8397**

❑ **Phoenix Metro Location**
2225 W. Peoria Ave., Ste. 150
Phoenix, AZ 85029
Main: **602-395-5089**
Fax: **602-395-3335**

❑ **Phoenix West Location**
9150 W. Indian School Rd., Ste. 136
Phoenix, AZ 85037
Main: **623-772-6840**
Fax: **623-772-6844**

Patient Name _____ D.O.B. _____

Clinical History / Diagnosis: _____

❑ Primary Phone# _____ ❑ Call patient to schedule _____

❑ Alternate Phone # _____ ❑ Patient to carry ❑ Paper Film ❑ CD

❑ Deliver Images to _____ ❑ Compare to prior films ❑ DVR ❑ Other _____

❑ STAT Call Report # _____ Insurance _____

❑ Authorization needed _____ ❑ Authorization / Claim # _____

WE PROVIDE AUTHORIZATION: With Copy of Insurance Card (Front & Back) and Physician Notes

❖ *PLEASE BRING THIS PAPER TO YOUR APPOINTMENT* ❖

If the patient is a minor and is not accompanied by the legal guardian, a notarized letter of consent is required.

ULTRASOUND

❑ Abdomen ❑ Testicular w/dop. prn
❑ Renal ❑ Extremity R L
❑ Renal Artery Doppler
❑ Pelvic w/transvag. prn
❑ Obstetric
❑ Thyroid
❑ Extracranial Carotid
❑ Peripheral Art. w/ABI prn R L Bil LE U E
❑ Peripheral Venous R L Bil LE UE
❑ Other _____
(Bell only)
❑ Venous Insufficiency R L Bil LE

LOW DOSE DIGITAL MAMMOGRAPHY

❑ Bilat, Screening *(Add. Views & US if needed)*
❑ Diagnostic bilat. unilat. *(US if needed)*
❑ Breast Ultrasound *(Diagnostic Mammo if needed)*
❑ Breast Biopsy *(US Guided)*
❑ Cyst Aspiration

DEXA

❑ Bone Density
❑ Vertebral Assessment
❑ Body Comp

IVP *(Bell only)*

❑ IVP W Tomograms *(consider Renal Stone CT or CT/IVP)*
❑ VCUG
❑ Cystogram

FLUOROSCOPY *(Bell only)*

❑ Esophogram ❑ BE with air
❑ Upper GI (UGI) ❑ BE without air
❑ UGI & Small Bowel ❑ Hysterosalpingogram
❑ Small Bowel Series *(consider CT Enterography)*

MRI

❑ W/O Contrast
❑ W & W/O Contrast ❑ Per Radiologist
❑ Brain w/orbit xray prn _____
❑ Pituitary w/orbit xray prn
❑ Orbits wa/orbit xray prn
❑ IAC's w/wo w/orbit xray prn
❑ Neck (Soft Tissue) w/orbit xray prn
❑ Chest w/orbit xray prn
❑ Brachial Plexus w/orbit xray prn
❑ Spine C T L w/orbit xray prn
❑ Abdomen w/orbit xray prn
❑ MRCP w/orbit xray prn
❑ Pelvis w/orbit xray prn
❑ Arthrogram MRI _____
w/orbit xray prn
❑ Extremity R L _____
w/orbit xray prn
❑ **MRA:** _____
w/orbit xray prn _____

X-RAY (Walk-Ins)

❑ Abdomen ❑ Chest ❑ KUB
❑ Hand ❑ Foot ❑ Ankle ❑ Knee
❑ R ❑ L ❑ Bil
❑ Weight Bearing 2 views 3 views
❑ Sinuses: Waters Series
❑ Pelvis / Hip: R L Bil
❑ Spine: C T L
❑ Orbits
❑ Extremity: R L _____
❑ Misc: _____

OTHER

❑ Therapeutic Musculoskeletal Injection
Anatomical Site _____
(circle one) US FL *(Bell only)* CT Guided

CT (Walk-Ins)

❑ W/O Contrast ❑ Per Radiologist
❑ W & W/O Contrast
❑ Head
❑ Facial Bones w/3D prn
❑ Orbits w/3D prn
❑ Sinus w/3D prn
❑ Temporal Bones w/3D prn
❑ Neck w/3D prn
❑ Chest w/3D prn
❑ Chest HiResolution w/3D prn
❑ Chest (Pulmonary Embolism Protocol) w/3D prn
❑ Abd w/Pelvis w/3D prn
❑ Pelvis w/3D prn
❑ CT/IVP (Urogram) w/3D prn
❑ Abd w/ Pelvic Renal Stone Protocol w/3D prn
❑ CT Enterography w/3D prn
❑ Spine C T L
❑ Extremity w/3D prn R L _____

CTA (Walk-Ins)

❑ Head
❑ Neck (Carotids)
❑ Chest (Pulmonary Embolism Protocol)
❑ Thoracic Aorta (Chest Only)
❑ Thorocoabdominal and Aorta
(chest, abd & pelvis for aneurysm or dissection)
❑ Abdomen Aorta (AAA)
❑ Renal Artery w/renal US prn
❑ Aorta-Femoral Runoff
❑ Pelvis
❑ Upper Extremity R L
❑ Lower Extremity R L

❑ ***OTHER EXAMS NOT LISTED:*** _____

❑ Transportation needed (DVR will provide)

REFERRAL COORDINATOR

REFERRING PHYSICIAN (PLEASE PRINT)

REFERRING PHYSICIAN PH # | REFERRING PHYSICIAN FAX #

DOCTOR SIGNATURE

As Ordered **X** _____ Date _____

Per Radiologist **X** _____ Date _____

PLEASE BRING PRIOR X-RAY EXAMS INCLUDING CT, MRI, ULTRASOUND AND MAMMOGRAMS.

The patient is scheduled _____ Time _____ AM / PM