



# 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 \_\_\_\_\_

URGENT  STAT  ROUTINE

**LOCATIONS:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <b>Phoenix Children's Hospital</b><br>1919 E. Thomas Rd.<br>Phoenix, AZ 85016 | <input type="checkbox"/> <b>Phoenix Children's Specialty and Urgent Care East Valley Center</b><br>5131 E. Southern Ave.<br>Mesa, AZ 85206 | <input type="checkbox"/> <b>Phoenix Children's Specialty and Urgent Care Northwest Valley Center</b><br>20325 N. 51st Ave., Suite 116<br>Phoenix, AZ 85308<br><i>(X-ray only at this location)</i> |
|--|--|--|

**EXAM REQUESTED**

SEDATION  GENERAL ANESTHESIA

**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 PET (FD6)**

- Whole Body
- Eyes to Thighs
- Brain
- C11 Brain

**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)\*\*\*

\*\*\* Scheduled examination, must be scheduled with Imaging in advance

**SPECIAL NEEDS:**

**HISTORY:**

**WRITTEN DIAGNOSIS**

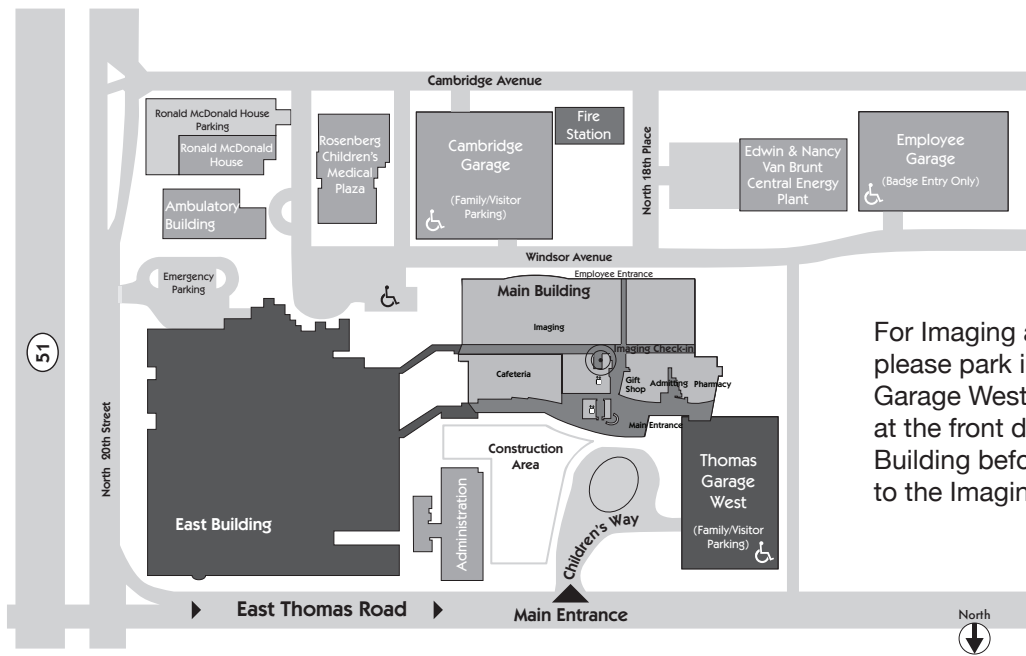
Check here if additional clinical information is included with this order

**PHYSICIANS/PA/NP SIGNATURE:** \_\_\_\_\_

**PHOENIX CHILDREN'S HOSPITAL-MAIN CAMPUS**

**Main Campus**

1919 E. Thomas Rd.  
Phoenix, AZ 85016

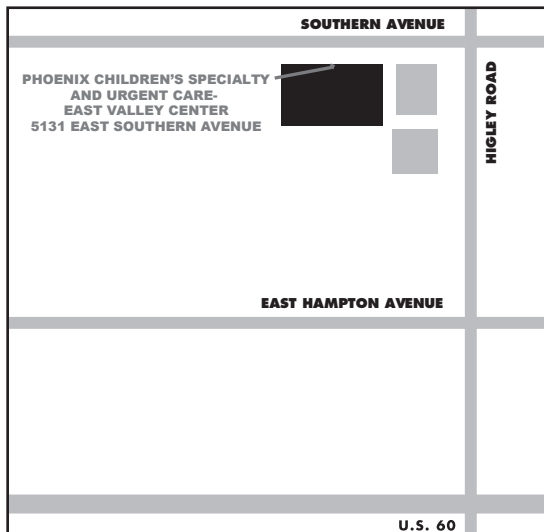


For Imaging appointments please park in Thomas Garage West and check-in at the front desk of the Main Building before proceeding to the Imaging Check-in

**PHOENIX CHILDREN'S SPECIALTY AND URGENT CARE**

**East Valley Center**

5131 E. Southern Ave.  
Mesa, AZ 85206



**Northwest Valley Center**

20325 N. 51st Ave., Suite 116  
Phoenix, AZ 85308  
*X-ray only at this location*

