



**PHOENIX
CHILDREN'S
Hospital**

REFERRAL FORM – RADIOLOGY

Main number – (602) 546-1213
 Radiology scheduling – (602) 546-1215 Fax (602) 546-1214
 Interventional scheduling – (602) 546-4444 Fax (602) 546-1587

Referral Date:

PATIENT INFORMATION

Patient Legal Name:		First	Middle	Last
Birth date:		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Patient Weight:
Street address:		City:	State:	Zip:
Home Phone:	Work Phone:		Cell:	

PARENT/GUARDIAN

Parent Name:		Relationship:		
Parent Address (if different from above):		City:	State:	Zip:
Home Phone:	Work Phone:		Cell:	
Parent Email:		Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Language Spoken:		

PRIMARY INSURANCE INFORMATION

Insurance Carrier:				
Insurance Address:		City:	State:	Zip:
Policy #:		Group#:		
Subscriber Name:		Subscriber DOB:		
Authorization Required <input type="checkbox"/> Yes <input type="checkbox"/> No Not sure: (link to various websites)		Authorization #:		

SECONDARY INSURANCE INFORMATION (If Applicable)

Insurance Carrier:				
Insurance Address:		City:	State:	Zip:
Policy #:		Group#:		
Subscriber Name:		Subscriber DOB:		
Authorization Required <input type="checkbox"/> Yes <input type="checkbox"/> No Not sure: (link to various websites)		Authorization #:		

REFERRING PROVIDER

Referring Provider Name:		Primary Care Provider Name (if different from Referring):		
Practice Name:				
Address:		City:	State:	Zip:
Contact:	Office Phone:	Backline Phone:	Email (mandatory):	

APPOINTMENT REQUEST

Specialty:		Location:		
Appointment time preference: <input type="checkbox"/> AM <input type="checkbox"/> PM				
Primary Diagnosis:		Codes:		

INTERNAL USE ONLY

Intake	Referral Acceptance	Appointment Data
Date Referral Received:	Referral Accepted: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date: Time:
First Contact:	Provider:	Provider:
Division/Provider Referred to:	Signature:	Date contact or letter sent:
Completed By:	Completed By:	Completed By:

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PATIENT NAME:

REFERRAL DATE:

SEDATION GENERAL ANESTHESIA

***Scheduled examinations, must be scheduled with Radiology in advance

X-RAY (Please be specific)

<input type="checkbox"/> Chest (1 view)	<input type="checkbox"/> Extremity view/side	<input type="checkbox"/> Barium Enema (BE)***
<input type="checkbox"/> Chest (2 views)	<input type="checkbox"/> Extremity view/side	<input type="checkbox"/> Upper GI (UGI)***
<input type="checkbox"/> Sinus— view	<input type="checkbox"/> Extremity view/side	<input type="checkbox"/> UGI/Small Bowel***
<input type="checkbox"/> Skull— view	<input type="checkbox"/> Other –	<input type="checkbox"/> Voiding Cystourethrogram (VCUG)***
<input type="checkbox"/> Neck (soft tissue)		<input type="checkbox"/> Intravenous Pyelogram (IVP)***
<input type="checkbox"/> Spine— view		<input type="checkbox"/> Modified Barium Swallow (with speech)***
<input type="checkbox"/> Scoliosis		<input type="checkbox"/> DEXA
		<input type="checkbox"/> Other
<input type="checkbox"/> Other Non-Radiology Outpatient Tests Ordered		

ULTRASOUND*

NUCLEAR MEDICINE*

<input type="checkbox"/> Head***	<input type="checkbox"/> Bone Scan***
<input type="checkbox"/> Renal (Kidney)***	<input type="checkbox"/> GFR***
<input type="checkbox"/> Abdomen***	<input type="checkbox"/> MAG-3***
<input type="checkbox"/> Pelvis***	<input type="checkbox"/> Gastric Emptying***
<input type="checkbox"/> Hip***	<input type="checkbox"/> DMSA***
<input type="checkbox"/> Pyloric***	<input type="checkbox"/> Other***
<input type="checkbox"/> Testicular/Pelvic Doppler***	
<input type="checkbox"/> Other***	

CT

CONTRAST (specify)

SEDATE (specify)

	w/cont	w/o	w&w/o	with	w/o	General
<input type="checkbox"/> Sinus***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen/Pelvis***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Specify)***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRI

CONTRAST (specify)

SEDATE (specify)

	w/cont	w/o	w&w/o	with	w/o	General
<input type="checkbox"/> Head***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spine (Specify)***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Specify)***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Needs:

History:

Symptoms:

Check here if additional clinical information is included with this order

Physicians/PA/NP Signature: