



# CENTRALIZED SCHEDULING FAX REQUEST

**Radiology Ltd.**  
**Diagnostic Imaging Services**  
Centralized Scheduling Tel: (520)733-SCAN (7226)  
Toll Free: 1-866-565-2220

**To schedule an appointment, please fax to: (520)290-8377**

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_\_) \_\_\_\_\_  
PATIENT: (First Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_  
DOB: \_\_\_\_\_ HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_  
WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_ BEST TIME TO CONTACT: \_\_\_\_\_ AM PM  
PATIENT INSURANCE: \_\_\_\_\_ Ins. Phone: (\_\_\_\_\_) \_\_\_\_\_  
POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
PRIOR AUTHORIZATION # (if needed): \_\_\_\_\_ Would you like authorization assistance?  YES  NO

*If you would like us to assist in obtaining the authorization, please include all clinicals, history sheets, and progress notes with order.*  
**NOTE:** We are unable to provide authorization assistance for STAT cases and APIPA, APIPA Senior, Mercy Care, Cigna, and United Healthcare insurances.

- LOCATION:**
- |  |   |
|--|---|
| <input type="checkbox"/> IST Available                                       | <input type="checkbox"/> Radiology Ltd. - Carondelet                      |
| <input type="checkbox"/> Camp Lowell Imaging Center                          | <input type="checkbox"/> Rancho Vistoso Diagnostic Imaging                |
| <input type="checkbox"/> La Cholla Center for Diagnostic Imaging & Treatment | <input type="checkbox"/> St. Joseph's Imaging Center                      |
| <input type="checkbox"/> La Cholla Center for Women's Imaging                | <input type="checkbox"/> Wilmot Center for Diagnostic Imaging & Treatment |
| <input type="checkbox"/> Midvale Imaging Center                              | <input type="checkbox"/> Wilmot Center for Women's Imaging                |

Procedure(s) Requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinical Indication / Dx: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Required** for diabetic patients having CT & MRI exams Creatinine Level: \_\_\_\_\_ Date of Test: \_\_\_\_\_  
Previous Films:  YES  NO When: \_\_\_\_\_ Where: \_\_\_\_\_

**Referring Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**An exam appointment confirmation will be faxed as soon as the appointment has been scheduled.**

The information contained in this facsimile message is CONFIDENTIAL and/or LEGALLY PRIVILEGED information intended only for the use of the facility named above. If you received this in error, please call (520)545-1969.