SUN RADIOLOGY
"The Leader in Quality Medical Imaging"

Designated Practice Schedule Available

ATTORNEY/LIEN/WORKMAN

Online: www.SunRadiology.com
Phone: 623-815-8200
Fax: 623-815-8299

Tax ID: 86-1048897
Hablas Español
Request CD of Images Online

☐ STAT FAX ☐ STAT CALL ☐ PT HAND CARRY

PATIENT NAME:_____ DOB:_____ DATE:_____

PHONE:_____ TEXT ○ Y ○ N _____ Lien/Attorney/Workman Comp _____

MECHANISM OF INJURY: ☐ MVA ☐ OTHER:_____ DATE OF INJURY:_____

CLINICAL HISTORY/ HISTORY OF INJURY:_____

☐ REPORT ○ Routine ○ ASAP ○ CC Report to:_____ ○ Routine ○ STAT

ATTORNEY/LAWYER:_____ LEGAL ASSISTANT:_____

LAW OFFICE NAME:_____

ADDRESS:_____

PHONE:_____ FAX:_____ CONTACT EMAIL:_____

Lien/Workman Comp Checklist

☐ Bring attorney's information/law firm business card ☐ Police Report or Collision Form
☐ Personal and At-Fault (3rd Party) Insurance Information

Clinical History

☐ Pacemaker
☐ Metal Fragments
☐ Pregnant
☐ Claustrophobic
☐ Medical History *(please attach)*

MRI 3D Rendering

☐ High Field MRI

☐ Oral sedation
☐ W/WO IV contrast
☐ W IV contrast
☐ W/O IV contrast
☐ IV contrast per radiologist

Will include XR orbit screening as necessary

☐ Brain ○ IACs ○ Pituitary ○ Neuroquant ○ TBI Protocol ○ Orbits ○ Lesionquant
☐ Neck Soft Tissue
☐ Brachial Plexus R L Bil
☐ Spine C T L Sacrum
☐ Chest
☐ Breast CAD/30
☐ Pelvis
☐ MRI Arthrogram:
☐ TMJ
☐ Joint R L Bil
○ Shoulder ○ Elbow ○ Wrist
○ Hip ○ Knee ○ Ankle ○ Digit
☐ Extremity R L Bil
☐ Upper Arm ○ Forearm ○ Hand
○ Thigh ○ Calf ○ Foot

Head
☐ Brain ☐ TBI Protocol ☐ Orbits ☐ TMJ
☐ IACs ☐ Sinuses ☐ Other_____

Spine
☐ Cervical ○ ALAR Ligament (Skull Base)
☐ Thoracic
☐ Lumbar

Upper Extremity
☐ Shoulder ○R ○L
☐ Elbow ○R ○L ☐Wrist ○R ○L
☐ Hand ○R ○L ☐Other_____

Lower Extremity
☐ Hip ○R ○L ☐Ankle ○R ○L
☐ Knee ○R ○L ☐Foot ○R ○L
☐ MR Arthrogram _____
with imaging guidance as needed

MRA HEAD/BRAIN

☐ Head (Brain) ☐ Neck (Carotids)

Ultrasound

VASCULAR ARTERIAL
☐ Carotid
☐ Aorta / Iliac Duplex
☐ Upper Extremity R L Bil
☐ Lower Extremity / ABI R L Bil

VASCULAR VENOUS
☐ DVT Upper Extremity R L Bil
☐ DVT Lower Extremity R L Bil

WALK IN

REFERRING OFFICE

Practice Name:_____
Address_____
Phone_____ Fax:_____
Email:_____

HEALTHCARE PROVIDER SIGNATURE

Print_____
Sign_____ Date_____

X-Ray

☐ Sinus ○Waters ○Series
☐ Skull ○ Mandible ○ Sinus
☐ Chest 1 view (PA)
☐ Chest 2 views (PA&LAT)
☐ Shoulder R L Bil
☐ Pelvis AP
☐ Rib Series w/CXR R L Bil
☐ Spine 3 Views: C T L Add Flex/Ext
☐ Spine 5 Views: C T L Add Flex/Ext
☐ Spine 7 Views: C T L Add Flex/Ext

WALK IN

Weight Bearing
☐ Hip w/Pelvis: R L Bil
☐ Femur: R L Bil
☐ Knee: R L Bil
☐ Tibia / Fibula: R L Bil
☐ Ankle: R L Bil
☐ Foot: R L Bil
☐ Toe: R L Bil
☐ Humerus: R L Bil
☐ Elbow: R L Bil
☐ Radius / Ulna: R L Bil
☐ Wrist: R L Bil
☐ Hand: R L Bil
☐ Finger: R L Bil
☐ SI Joint: R L Bil

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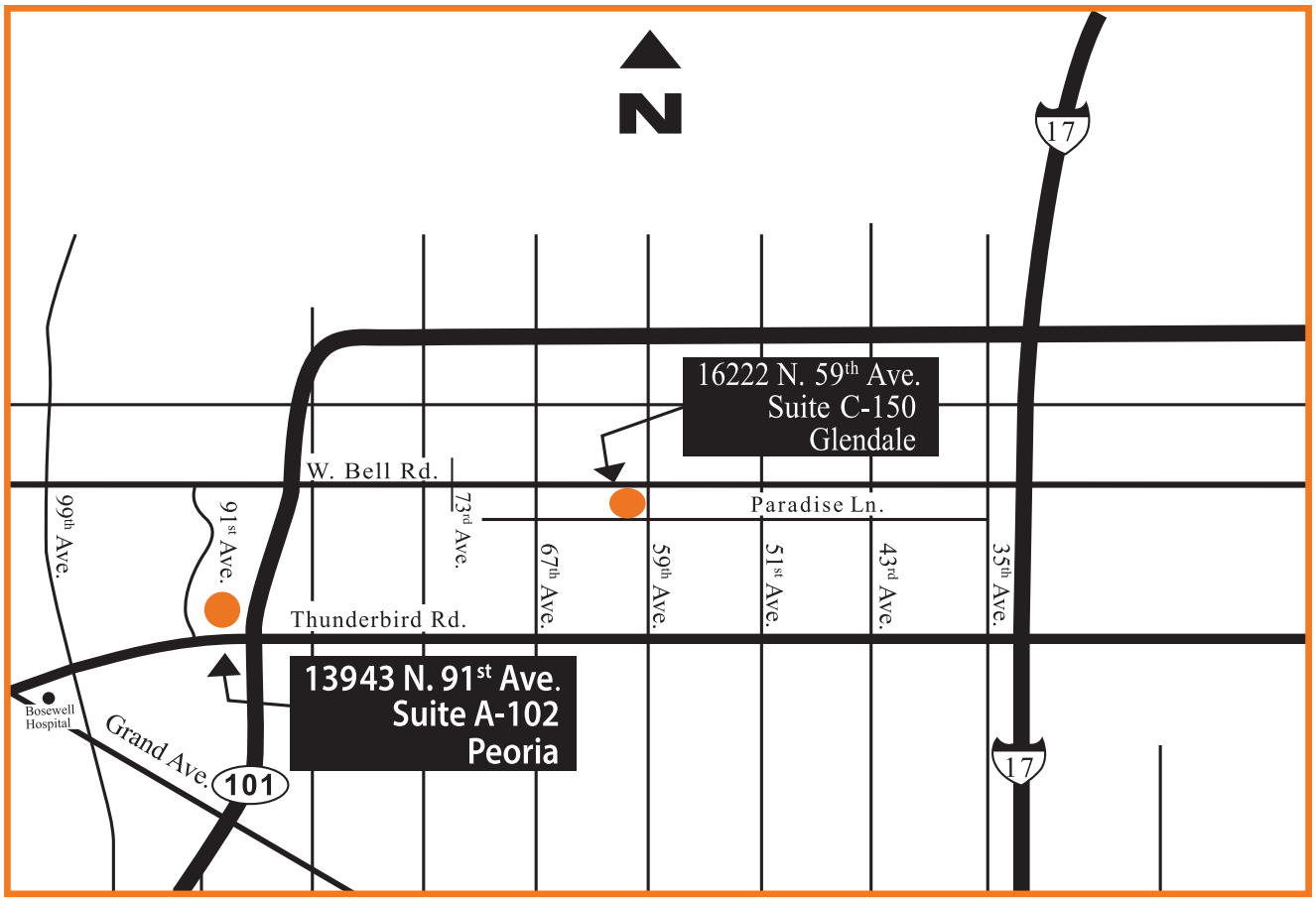
Online Patient Scheduling www.sunradiology.com

Designated Practice Scheduler Available



Quick Reference Guide

1. Online Patient Scheduling: **www.SunRadiology.com**
2. To schedule an appointment - 623.815.8200, 1 - English. 2 - Spanish. Option 1.
3. To reach medical records - 623.815.8200, 1 - English. 2 - Spanish. Option 3.