



# RADIOLOGY REFERRAL

Ph: 702-759-8600  
Fx: 702-598-3439

Your appointment is scheduled / Su cita está previsto:

Date/Fecha: \_\_\_\_\_ Time/Hora: \_\_\_\_\_

Arrival Time/Hora de llegada: \_\_\_\_\_

DATE OF ORDER: \_\_\_\_\_  
(required)



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_ Work/Alt \_\_\_\_\_

Primary Ins \_\_\_\_\_ Policy # \_\_\_\_\_

Authorization # \_\_\_\_\_ Authorization Effective Date(s): \_\_\_\_\_

**Desert Radiology OBTAIN AUTHORIZATION**

*(Clinical notes must accompany this referral or be faxed within 48 hours for DR to obtain auth. Failure to send clinicals will result in scheduling delays).*

History / Symptoms (required) \_\_\_\_\_

ICD-10 / Diagnosis \_\_\_\_\_

Referring Physician \_\_\_\_\_

Ph \_\_\_\_\_ Fx \_\_\_\_\_ CC Physician \_\_\_\_\_

Office Contact \_\_\_\_\_  **STAT REPORT - CALL RESULTS TO:** \_\_\_\_\_

IMAGE DELIVERY:  CD to Office  CD w/ Patient  Paper Print

*\*\*Note: Desert Radiology has eliminated printing of plastic film. Images on film are no longer available. CD or paper prints available upon request.\*\**

X-ray (Walk-in basis ONLY, NO APPOINTMENTS) \_\_\_\_\_

Fluoroscopy \_\_\_\_\_

DEXA \_\_\_\_\_  ADD Vertebral Height

CTA \_\_\_\_\_  CTA Chest (PE)

CT \_\_\_\_\_  WO  W

CT Calcium Scoring  CT Lung Screening  CTE (ENTEROGRAPHY) abd/pelvis w/ IV  CTU (UROGRAM) abd/pelvis w/wo IV

*\*\*NOTE: CT Calcium Score may not be covered by insurance, including Medicare. Cash price available, call DR for more info.*

MRI \_\_\_\_\_  WO  W & WO  Arthrogram

MRA \_\_\_\_\_  WO  W & WO

MRV \_\_\_\_\_  WO  W & WO

Nuclear Medicine \_\_\_\_\_

Biopsy (Breast / Thyroid) \_\_\_\_\_

Ultrasound \_\_\_\_\_

US ABI  US Segmental Pressures  Segmental Pressures w/ ABI & TBI  US Arterial Duplex  US Pelvic & T-Vag

US Pelvic  US T-Vag

PET/CT Routine (Skull to Thigh)  PET/CT Brain  PET/CT Whole Body (Melanoma, Extremity Metastasis)

Interventional / Vascular Consult \_\_\_\_\_