



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 _____

*STAT scheduling requests will be given priority based on exam availability. Next available appointment will be offered at any DR Imaging Center.