DESERT RADIOLOGY
a radiology partners practice

WOMEN'S IMAGING 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)

☐ **STAT**
SCHEDULE*

Patient Name _____ DOB _____

Ph _____ Cell Ph _____ Work/Alt _____

Primary Ins _____ Policy # _____

Authorization # _____ Authorization Effective Date(s): _____

☐ **Desert Radiology OBTAIN AUTHORIZATION**
*(Clinical notes **MUST** accompany referral or be faxed within 48 hours for DR to obtain auth. Failure to send clinicals will result in scheduling delays or appt cancellation.*

History / Symptoms (required) _____

ICD-10 / Diagnosis (required) _____

Referring Physician _____

Ph _____ Fx _____ CC Physician _____

Office Contact _____ ☐ **STAT REPORT** - CALL RESULTS TO: _____

Mammography:

☐ Mammo **SCREENING** or Mammo **DIAGNOSTIC** w/ **US** *(as needed, per patient symptoms)*

☐ Mammo **SCREENING** *w/follow-up* **DIAGNOSTIC** w/ **US** *(as needed)*

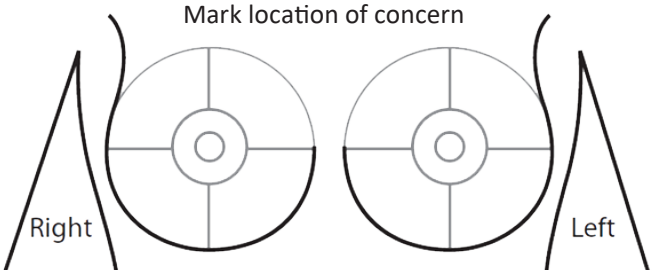
☐ Mammo **DIAGNOSTIC** w/ **US** *(as needed)*

☐ **3D** *(as requested - screening or diagnostic)*
3D may not be covered by insurance. Self-pay pricing available. Call DR for more info.

NEW SERVICE
☐ **MAMMO ENHANCE HEART** *(screening only)*
Mammo Enhance Heart is not covered by insurance. Self-pay only. Call DR for more info.

FOR DIAGNOSTIC MAMMO ONLY!!

Mark location of concern



ICD 10 CODE / DIAGNOSIS:

☐ Z12.31	Screening Mammogram	☐ N64.52	Nipple discharge
☐ N60.19	Breast cyst	☐ N64.53	Inversion of nipple
☐ N64.4	Breast tenderness / pain	☐ R92.0	Calcs/Micro calcifications
☐ N63	Lump or mass in breast	☐ R92.8	Additional imaging of breast
☐ C50.919	Breast Cancer	☐ R92.8	Breast follow up
☐ N64.51	Breast redness	☐ Z80.3	Family history breast cancer
		☐ Z85.3	Personal history breast cancer

Additional Women's Imaging:

☐ Breast US _____ ☐ Bilateral ☐ Left ☐ Right

☐ Breast MRI w/ & wo _____

☐ Ultrasound Other *(specify)* _____

☐ Breast Biopsy **STEREOTACTIC** _____

☐ Breast Biopsy **US Guided** _____

☐ Breast Biopsy MRI _____

☐ DEXA _____ ☐ ADD Vertebral Height

☐ X-RAY *(walk-in basis only, no Appointments)* _____

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