



7500 Smoke Ranch Road, Suite 100
Las Vegas, NV 89128
MRI HOURS
M-F: 7:30AM - 11PM
Sat: 8AM - 5PM

3201 S Maryland Parkway, Suite 102
Las Vegas, NV 89109
(Upright MRI & XRAY only)
MRI HOURS
M-F: 8:00AM - 5PM Sat: 8AM - 5PM

401 N Buffalo Drive, Suite 100
Las Vegas, NV 89145
(Ultrasound & DEXA only)

PHONE: 702.254.5004

MAIN FAX: 702.432.4005

ALT FAX: 702.586.2140

REFERRAL EMAIL: lvr-referrals@lvrad.com

PATIENT NAME: _____ DOB: _____ AGE: _____ GENDER: M F
 HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____
 LIEN/PERSONAL INJURY ATTORNEY: _____ DOI: _____
 INSURANCE: _____ ID/CLAIM #: _____ WORK COMP: _____
 DX/SYMPTOMS: _____ ALLERGIES: _____

Consent to Represent Ordering Provider During Prior Authorization Process

PRIOR AUTHORIZATION REQUESTED

STAT

Oral sedation needed
 Claustrophobic patient

By providing the following information, I authorize Las Vegas Radiology to represent my office during the prior-authorization process for the exams ordered on this referral.

Ordering Provider's NPI #: _____
Please fax clinical information needed for authorization.

REFERRING PHYSICIAN: _____ CONTACT NAME: _____

PHONE: _____ FAX REPORT TO: _____ TODAY'S DATE: _____

FAX REPORT SEND CD PT TO CARRY CD PICK UP COMPARISON CD FROM: _____

CC REPORT: _____ APPT TIME: _____ APPT DATE: _____ APPT LOCATION: _____

X-RAY (Walk-ins Welcome)
 Body Part _____
 Right Left Bilateral
 Number of Views _____
 Body Part _____
 Right Left Bilateral
 Number of Views _____

3D Rendering if MRI is Positive
 MRI
 Body Part _____
 Contrast: With W/O Both
 Radiologist Discretion
 Arthrogram

PET/CT (64 Slice)
 Brain (Dementia)
 Skull Base to Mid Thigh
 Whole Body (Melanoma & Bone Tumors)

FLUOROSCOPY
 Barium Enema
 SBFT (Small Bowel Follow Through)
 Upper GI with KUB
 Hysterosalpingogram (HSG)
 Lumbar Puncture (PT/INR Required)

UPRIGHT / OPEN MRI (Maryland Pkwy)
 Flexion Extension
 Body Part _____

CTA
 CTA Brain
 CTA Coronary
 CTA Abdomen w/ Runoff
 CTA Chest (PE Protocol)
 CTA Chest (Aorta)
 CTA Neck

MAMMOGRAPHY
 Annual Screening
 Diagnostic / Ultrasound

MRA
 Body Part _____
 Without W/O

CT SCAN
 Body Part _____
 Contrast: With W/O Both
 Radiologist Discretion
 CT Myelogram
 CT Post Discogram

NUCLEAR MEDICINE
 HIDA Scan Gastric Emptying
 Lymphocystogram Muga Scan
 Thyroid i131 Scan Thyroid i123 Scan
 V/Q Scan
 Whole Body Bone Scan
 3 Phase Bone Scan

DEXA
 Atypical Femur Assessment (Bisphosphonate Use)
 VFA (Vertebral Factor Assessment)

CORONARY CT CALCIUM SCORING (Cash \$100)

STRESS TEST
 Lexiscan Myoview
 Dobutamine Myoview
 Treadmill Myoview
 Treadmill Only (No Myoview)

ULTRASOUND
 Abdominal Aorta (Fasting 6 hours)
 Bilateral Carotid
 LE Arterial To R/O Pad _____
 LE Venous To R/O Venous Insufficiency _____
 LE Venous To R/O DVT _____
 Renal Arterial Doppler R/O RAS
 Upper Extremity U/S: _____
 Breast U/S: R L
 Other _____

LOW DOSE CHEST CT LUNG CA SCREENING

EKG

PROCEDURES (Blood Work Required)
 Thoracocentesis
 Paracentesis
 BIOPSIES
 Body Part _____
 CT Guided CT/US
 Ultrasound Guided
 Right Left Bilateral
 Bone Marrow

ECHOCARDIOGRAM _____

OTHER: _____