Phone: 855.476.1268

Fax: 877.330.0432

redrockradiology.com

PATIENT NAME: ______________________ **DAYTIME PHONE** ______________ **EVENING PHONE** ______________

PRIMARY INSURANCE ______________________ **SECONDARY INSURANCE** ______________________

DOB ____/____/____ **AUTHORIZATION NUMBER** ______________________

RED ROCK TO OBTAIN AUTHORIZATION ☐ **YES** ☐ **NO**

EXAMINATION REQUESTED

- ☐ X-RAY ______________________
- ☐ FLUORO ______________________
- ☐ CTSCAN ______________________
  - ☐ with IV contrast
  - ☐ without IV contrast
  - ☐ with and without IV contrast
- ☐ CT Angiogram ______________________
  - ☐ 3D reconstruction
- ☐ CT DEXA (Bone Densitometry)
- ☐ MAMMOGRAM (Red Rock Facility)
  - ☐ Diagnostic
  - ☐ Screening
- ☐ MRA ______________________
  - ☐ 3D reconstruction
- ☐ MRI ______________________
  - ☐ with IV contrast
  - ☐ without IV contrast
  - ☐ with and without IV contrast
- ☐ ULTRASOUND ______________________
- ☐ OTHER ______________________

MOUNTAINVIEW HOSPITAL ONLY

- ☐ NUCLEAR MEDICINE ______________________
- ☐ PET /CT

DIAGNOSIS / CLINICAL INFORMATION

ICD10 CODE /
SYMPTOMS ______________________

ALLERGIES ______________________

CONTACT: ______________________

PH # ______________ FAX # ______________

- ☐ FAX PRELIMINARY REPORT ______________
- ☐ PT TO WAIT UNTIL REPORT CALLED/CALL REPORT

Circle choice(s)

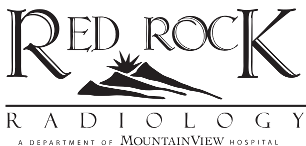
- ☐ SEND IMAGES AND REPORT TO OFFICE CD FILM
- ☐ RETURN PATIENT AND IMAGES TO OFFICE CD FILM

YOUR APPOINTMENT TIME IS SCHEDULED:
SU CITA ES A LAS:

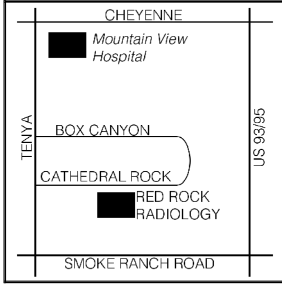
____/____/____ at ______________

PLEASE ARRIVE AT
POR FAVOR LLEGA A LAS: ______________

ORDERING PHYSICIAN SIGNATURE: ______________________________



OUTPATIENT PHYSICIAN ORDERS



☐ NORTHWEST OFFICE
7130 Smoke Ranch Road
Las Vegas, NV 89128

Phone: 855.476.1268

Fax: 877.330.0432

redrockradiology.com

Interventional Radiology
Call: 702.731.2888 x1
Fax: 702.947.7409

DATE ORDERED ______________________

PATIENT NAME: ____ **DAYTIME PHONE** _________________ **EVENING PHONE** ________________

PRIMARY INSURANCE ___________________________________ **AUTHORIZATION NUMBER** ____

SECONDARY INSURANCE ________________________________ **DOB** ____/____/____

RED ROCK TO OBTAIN AUTHORIZATION ____

PROCEDURE REQUESTED

☐ Carotid Angiogram

☐ Implantable venous access device

(Chest port, Arm port or PICC line)

☐ Leg Varicose Vein Treatment

☐ Myelogram (level) ______________________________

☐ Needle Aspiration / Biopsy __________________________

☐ Paracentesis

☐ Abdominal Aorta Angiogram

☐ Vertebroplasty

☐ Other ____

☐ FAX PRELIMINARY REPORT ____________________________

☐ SEND IMAGES AND REPORT TO OFFICE *Circle choice(s)* CD FILM

☐ ANY PREVIOUS STUDIES

WHEN _______________ WHERE _____________________________

DIAGNOSIS / CLINICAL INFORMATION

ICD10 CODE/
SYMPTOMS ___________________________________

ALLERGIES ___________________________________

Please fax all pertinent demographics, insurance cards and clinical notes/reports to 702-947-7409 and have patient bring diagnostic films to the consultation.

Interventional Radiologist:

☐ Lindsey Blake, MD

☐ Steven Davis, MD

☐ Sunil Gujrathi, MD

☐ Varoujan Kostanian, MD

☐ Shao-Pow Lin, MD

☐ Aaron Peterson, MD

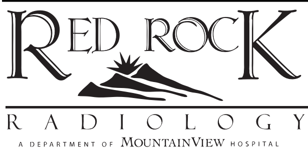
☐ Peter Weidenfeld, MD

☐ Other Radiologist ________________________

ORDERING PHYSICIAN SIGNATURE: ____

PH # ____________________________________ FAX # ____________________________________

CONTACT: ____



OUTPATIENT PHYSICIAN ORDERS