



SCHEDULING/CITAS
 Ph: (702) 387-6900
 Fx: (702) 598-3439

DATE OF ORDER: _____

STAT

PATIENT INFORMATION - Please complete ALL Information

Patient Name: _____ DOB: _____ Ph: _____ Alt Ph: _____

Primary Ins: _____ Authorization/Claim #: _____

ICD-9 Code: _____ Symptoms: _____

PHYSICIAN INFORMATION - ALL areas below MUST be completed

Referring Physician: _____

Phone: _____ Fax: _____

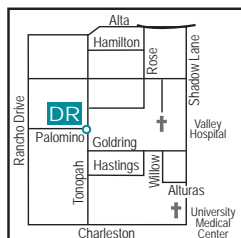
Office Contact: _____

CC Physician: _____

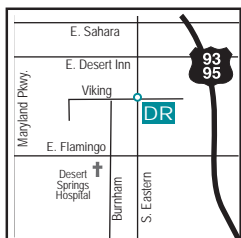
FILM & REPORT DELIVERY - Please select below

- CD to Office CD w/ Patient
- Other: _____
- CALL REPORT (Ph): _____

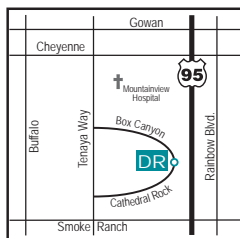
LOCATIONS



2020 Palomino Lane, Suite 100
 Las Vegas, NV 89106
 Directions/Direcciones: 759-8606



3920 S. Eastern Avenue
 Las Vegas, NV 89119
 Directions/Direcciones: 794-2190



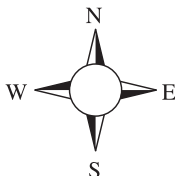
7200 Cathedral Rock Dr. Suite 230
 MRI - Suite 150
 Las Vegas, NV 89128
 Directions/Direcciones: 759-4300



4880 S. Wynn Road
 Las Vegas, NV 89103
 Directions/Direcciones: 759-4600



2811 W. Horizon Ridge Parkway
 Henderson, NV 89052
 Directions/Direcciones: 759-4500



EXAM INFORMATION - Scheduling Fax Number: 598-3439

- X-ray _____
- Fluoroscopy _____
- DEXA Add Vertebral Height Assessment
- CTA _____
- CTA Chest (PE - Pulmonary Embolism)
- CT _____
 Contrast: Without With Oral Per Rad
- CTU (Urogram) CTE (Enterography)
abd/pelvis with & without I.V. abd/pelvis with I.V.
- CT Calcium Scoring
- MRI _____
 Contrast: Without With & Without Arthrogram
- MRA _____
- Nuclear Medicine _____
- Screening Mammography Diagnostic Mammography
(U/S as needed)
- Screening Mammography / CALL BACK IF NEEDED
(extra views & U/S as needed)
- Breast Biopsy *(To schedule call 759-8969 or fax 384-3671)*
 Stereotactic US Guided MRI
- Biopsy Other *(location)* _____
- U/S: Abdomen Retroperitoneal OB
 Pelvic *plus* T-Vag Pelvic T-Vag
 Gallbladder Other _____
- Angiography *(To schedule call 734-6741 or fax 734-9799)*

- CT Biopsy *(To schedule call 794-4384 or fax 733-1213)*

- PET/CT *(To schedule call 794-4384 or fax 733-1213)*
 Routine (Skull to Thigh) Brain
 Whole Body (Melanoma, Extremity Metastasis)

Please be sure to bring your health insurance card, picture I.D. and co-payment with you, as well as any x-ray studies pertaining to your scheduled exam. If you might be pregnant, please contact our scheduling department before your appointment. See the reverse side of this form for important information regarding preparations for your examination and lab tests required. Por favor, asegúrese de llevar su tarjeta de aseguranza, identificación con fotografía y co-pago con usted, así como cualquier placa de rayos x estudios relativos a su examen programado. Si usted pudiera estar embarazada, póngase en contacto con nuestro departamento de programación antes de su cita. Véa el reverso de este formulario para información importante acerca de los preparativos para su examen y análisis de laboratorio necesarios.