Reno Diagnostic Centers

When it has to be done right.

Centralized Scheduling
FAX (775) 333-2776

Exam Date/Time:	Patient Name:	Date of Birth:

Patient Home/Work/Cell Number:	Patient Email:

Exam #1 Requested: CONTRAST: ☐ W/ ☐ W/O ☐ W/ & W/O

☐ LEFT ☐ RIGHT ☐ BILATERAL

Radiologist may modify CT or MRI use of contrast media based on patient's history.
☐ No, radiologist may not change exam protocol unless new written or verbal order is obtained.

Reason for Exam #1 (signs/symptoms - no R/O diagnosis):

ICD-10 Code (required):

Exam #2 Requested: CONTRAST: ☐ W/ ☐ W/O ☐ W/ & W/O

☐ LEFT ☐ RIGHT ☐ BILATERAL

Radiologist may modify CT or MRI use of contrast media based on patient's history.
☐ No, radiologist may not change exam protocol unless new written or verbal order is obtained.

Reason for Exam #2 (signs/symptoms - no R/O diagnosis):

ICD-10 Code (required):

Additional Exam(s)/Notes:

M Modifiers (required):

Pregnant? ☐ Yes ☐ No

Comprehensive Breast Cancer Risk Assessment Services:

SCREENING *(no symptoms present)*
- ☐ **Not Dense Breast Tissue/Unknown**- 3D Mammogram
- ☐ **Dense Breast Tissue**- 3D Mammogram + ABUS
- ☐ **High Risk** *(Lifetime Risk/TC Score 20+)* - 3D Mammogram + Breast MRI w/wo

DIAGNOSTIC *(symptoms present)*
- ☐ **3D Mammogram**- Diagnostic *(w/ handheld breast US if indicated)*
- ☐ **US-Guided Biopsy**
- ☐ **Stereotactic Biopsy**

X-ray

Please provide walk-in X-ray patients with hand-carry orders to expedite the process. We also offer scheduled appointments!

Ultrasound
- Pelvic:
  - ☐ Transabdominal
  - ☐ Transvaginal
  - ☐ Both Transabdominal & Transvaginal *(if indicated)*

3T Wide Bore MRI
1.5T Wide Bore MRI
64-Slice CT
Coronary CT
- ☐ BUN Testing *(if needed for contrast)*

Nuclear Medicine
- *Gastric Emptying (Tougas Protocol)*
- *Myocardial Perfusion Imaging (Lexiscan)*

PET/CT
Digital Fluoroscopy
DEXA - Bone Density Testing
Echocardiogram (including Pediatrics)
Body Fat Analysis

☐ **Normal**	☐ **Expedited**	☐ **STAT**
Provider fax number:	Report will be faxed within 4 hours.*	Report will be called within 2 hours.*
Report will be faxed within 24 hours.*	**Provider fax number:**	**Provider cell phone:**

** Except for after hours, weekends, and holidays.*

Send To:

Send Images On: ☐ CD ☐ Paper ☐ Patient to hand carry

Previous Images Located:

Name of Health Plan:	ID #:	Authorization #:

Please send all applicable clinical notes, insurance card, and demographics.

Referring Provider Signature:	Referring Provider Name & Address:	Today's Date:

Please bring this requisition with you.

Please check location.

**See back for maps.*

☐ **Carson City**
896 W. Nye Ln., Ste. 102
Carson City, NV 89703

☐ **Downtown Reno**
590 Eureka Ave.
Reno, NV 89512

☐ **Southwest Reno**
625 Sierra Rose Dr.
Reno, NV 89511