NEVADA IMAGING CENTERS

AUTHORIZATION SUPPORT
- ☐ Copy front and back of insurance card
- ☐ Fax appropriate physician notes

SCHEDULING DEPT. #: 702-891-9729
AUTHORIZATION FAX #: 702-433-3924

☐ NIC Spring Valley (Southwest)
☐ NIC Siena (Anthem)

PATIENT NAME: _____ DOB: _____ DATE: _____

PHONE: (DAY) _____ (CELL) _____ ☐ CALL PT. TO SCHEDULE

CLINICAL HX/DX: _____ INS. AUTH: _____ ☐ LIEN

_____ GFR/CR: ○Y ○N Date: _____

INSURANCE: _____ ALLERGY: ○Y ○N _____

HEALTHCARE PROVIDER NAME: (Print) _____ PHONE: _____

HEALTHCARE PROVIDER SIGNATURE: _____ FAX: _____

I hereby authorize **NIC** *to act on my behalf to obtain any and all authorizations needed for the above named patient. I hereby certify that the test ordered are medically necessary for the diagnosis and treatment of this patient.*

☐ ROUTINE FAX: _____ ☐ STAT FAX: _____ ☐ STAT CALL: _____

☐ PATIENT TO CARRY CD/FILMS: _____ ☐ CD ☐ FILMS TO: _____ ☐ CC REPORT TO: _____

Ultrasound
(Doppler if indicated, 3D as indicated)

☐ Abdomen
☐ Abd. LTD / RUQ ☐ Abd w/ Duplex
☐ Renal w/ Bladder
☐ Renal Duplex
☐ Pelvic TA with TV
☐ Pelvic TA
☐ Scrotal with Duplex
☐ OB ○ 1st Trimester ○ OB 2nd / 3rd Trimester
☐ Thyroid
☐ Carotid
☐ Venous ○ UE ○ LE ○ R ○ L ○ Bil
☐ Arterial LE with ABI ○ R ○ L ○ Bil
☐ Arterial UE ○ R ○ L ○ Bil
☐ UE Venous with mapping for graft
☐ Other: _____

X-Ray

☐ Abdomen: ○ 2 View ○ KUB
☐ Chest: ○ 1 View ○ 2 View
☐ Foot: ○ R ○ L ☐ Knee: ○ R ○ L
☐ Ankle: ○ R ○ L
☐ Elbow: ○ R ○ L ☐ Hand: ○ R ○ L
☐ Wrist: ○ R ○ L
☐ Shoulder: ○ R ○ L
☐ Hip (w/pelvis): ○ R ○ L
☐ Pelvis AP
☐ Spine Ltd. 3V: ○ C ○ T ○ L ○ Add Flex/Ext
☐ Spine Comp. 5V: ○ C ○ T ○ L ○ Add Flex/Ext
☐ Scoliosis
☐ Sinus: ○ Waters ○ Series
☐ Other: _____

CT
(3D recon if indicated) (IStat if indicated)

☐ w/wo contrast per rad ☐ no IV contrast

☐ Abdomen (with pelvis if indicated)
☐ Enterography
☐ Abdomen with Pelvis
☐ Kidney Stone (A-P w/o)
☐ CT/IVP (urogram)
☐ Brain
☐ Pelvis (with abdomen if indicated)
☐ Mylegraphy
☐ Neck (soft tissue)
☐ Sinus (maxillofacial)
☐ Temporal Bones
☐ Orbits
☐ Spine: ○ C ○ T ○ L
☐ Extremity: _____
☐ Other: _____
_____
_____

Fluoroscopy

☐ IVP (no tomo)
☐ Esophogram
☐ UGI
☐ Hysterosalpingogram
☐ Other: _____
_____
_____
_____

MRI
(3D recon if indicated) (IStat if indicated)
(Orbital X-ray as needed)

☐ w/wo contrast per rad ☐ no IV contrast

☐ Brain ☐ w/MRA
☐ IAC's ☐ Pituitary ☐ Orbits
☐ Spine: ○ C ○ T ○ L
☐ TMJ
☐ Neck MRA
☐ Neck Soft Tissue
☐ Brachial Plexus ○ R ○ L ○ Bil
☐ Chest
☐ Heart
☐ Abdomen _____
○ Liver ○ Kidney ○ Adrenal Glands ○ Enterography
○ Pancreas ○ MRCP ○ MRA Renals
☐ Pelvis ☐ Eovist (Liver imaging)
☐ Prostate
☐ Joint ○ R ○ L ○ Bil
○ Shoulder ○ Elbow ○ Wrist ○ Hip ○ Knee ○ Ankle
☐ MR Arthrogram: _____
with imaging guidance as needed
☐ Extremity ○ R ○ L
○ Upper Arm ○ Forearm ○ Hand ○ Thigh ○ Calf ○ Foot
☐ MR Spectroscopy
☐ MRA: _____
○ Abdominal w/ run-off ○ Renal Arteries
○ Thoracic Aorta ○ Extremity ○ R ○ L
☐ MRV: _____
○ Head ○ Legs/AVF
☐ Other: _____
_____
_____
_____

Patient Instructions

FOR ALL MRI's: If you suspect you have metallic substance within your body or are in the first trimester of pregnancy, you may not be able to complete your MRI study. Please contact our office immediately.

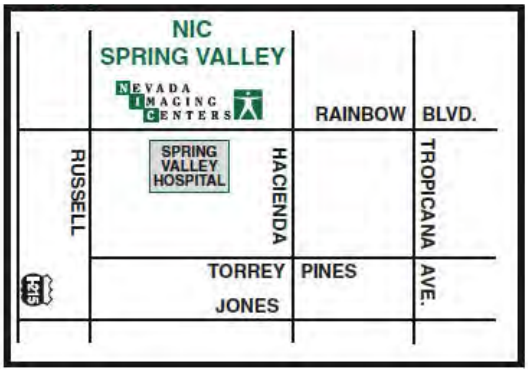
FOR ALL MRI's REQUIRING CONTRAST: If you are 60 or have hypertension, diabetes or cardiovascular disease you will require a BUN and Creatinine. Please contact your doctor's office for this blood work.

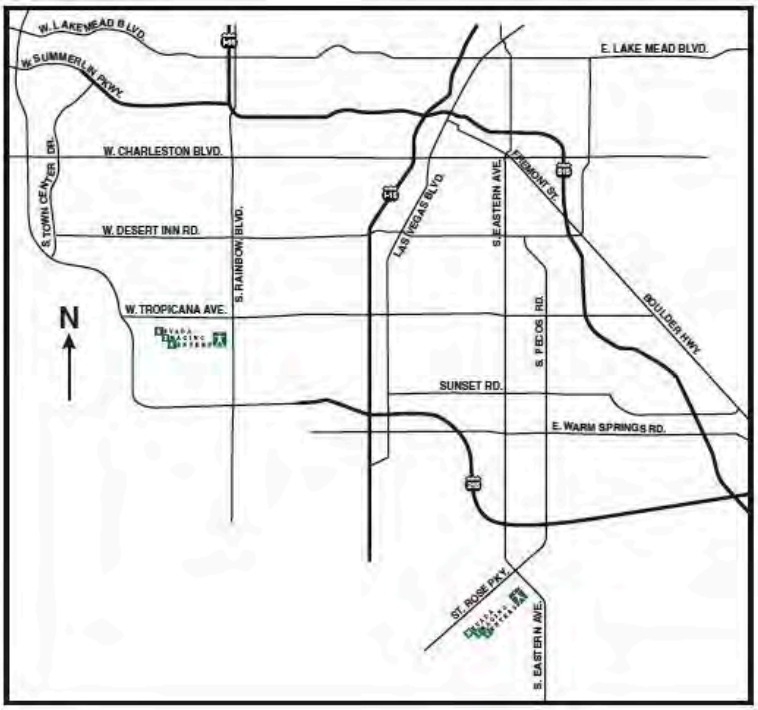
FOR ALL CT's REQUIRING CONTRAST: If you are 70 or have renal disease, hypertension, diabetes or cardiovascular disease you will require a BUN and Creatinine. Please contact your doctor's office for this blood work.

- ☐ **MRI (NON-HEAD):** No pacemakers, aneurysm clips, bio-nerve stimulators, eye injuries, or metal in the body.
- ☐ **MRI (HEAD):** No make-up, eye liners, hairspray or mousse the day of the exam. No pacemakers, aneurysm clips, bio-nerve stimulators, eye injuries, or metal in the body.
- ☐ **MRI (NON-HEAD):** No pacemakers, aneurysm clips, bio-nerve stimulators, eye injuries, or metal in the body.
- ☐ **CT SCAN (ABDOMEN AND PELVIS):** Nothing by mouth four (4) hours prior to the exam. A special liquid drink is required before your exam. Drink one full bottle two (2) hours prior to your test time. Drink 1/2 of the second bottle one (1) hour prior to your test and bring the other 1/2 bottle with you for your test. The drink may be provided by your doctor or may be picked up the day before your exam at one of our clinics. NO barium if the scan is for kidney stones.
- ☐ **CT SCAN WITHOUT CONTRAST (EXCEPT ABDOMEN AND PELVIS):** No prep.
- ☐ **CT SCAN WITH CONTRAST (EXCLUDING ABDOMEN AND PELVIS):** Nothing by mouth four (4) hours prior to test time.
- ☐ **ULTRASOUND (ABDOMEN, GALLBLADDER, PANCREAS, LIVER, AORTA, RENAL ARTERY):** Nothing by mount eight (8) hours prior to exam.
- ☐ **ULTRASOUND (KIDNEY):** Drink at least three eight ounce glasses of clear fluids before your exam.
- ☐ **ULTRASOUND (PELVIC, BLADDER, & TRANSABDOMINAL PROSTATE)):** Drink five eight ounce glasses of water within 60 minutes prior to your exam. DO NOT empty your bladder after drinking.
- ☐ **ULTRASOUND (OBSTETRIC):** One hour and thirty minutes prior to your appointment empty your bladder. Drink at four eight ounce glasses of water within 30 minutes of your exam. DO NOT empty your bladder after drinking.
- ☐ **ULTRASOUND (PROSTATE TRANSRECTAL):** Administer a Fleet Enema two (2) hours prior to your scheduled appointment.
- ☐ **FLUOROSCOPY EXAMS:** Please call our office for prep information.
- ☐ **PEDIATRIC EXAMS:** Please call our office for prep information.
- ☐ **IV SEDATION:** Please call our office for prep information.

To Schedule an Appointment Contact Our Scheduling Department at 891-9729

☐ **NIC Spring Valley (Southwest)**
5495 S. Rainbow Blvd., Suite 101
Las Vegas, NV 89118
(702) 214-9729





☐ **NIC Siena (Anthem)**
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NEVADA IMAGING CENTERS

Our Knowledge Is Your Confidence

NVMAIN4.13