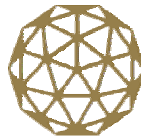
Scheduling & Pre Authorization Fax Request
(775) 333-2776 Centralized Office Fax
www.renodiagnosticcenters.com



Reno Diagnostic Centers

775-323-5083

Please accompany this form with patient's insurance card (front & back) demographics and H&P

PATIENT INFORMATION:

Name: (last) ______________________________ (first) ______________________________ (m.i.) _______

DOB:(mm/dd/yyyy) ___/______/_________ SS#______________________________ Pregnant? Y N

Phone: (home) ________________________ (work) ________________________ (cell) _________________

Employer: ____ Male or Female? *(circle one)*

PREVIOUS FILMS: Y N Location:_____________________________ Phone # _______________________

PROCEDURE TO BE SCHEDULED:

Preferred Facility? *(circle one)* Sierra Rose (625 Sierra Rose Dr.) OR Eureka (6th & Wells)
Preferred Date/Time? ____

DIAGNOSIS:

INSURANCE INFORMATION: Primary Insurance:___________________________ Auth #_______________
Secondary Insurance: _________________________ Office to obtain Auth______ No Auth Required______

PLEASE FILL OUT PRE AUTH SECTION ONLY IF RDC IS TO OBTAIN THE PRE AUTH

PRE AUTHORIZATION

Same as Patient? __________ Other? ____________ Grantor Name: ______________ Phone: __________
Relationship to Patient: ________________________ SS#________________________ DOB: __________
Address: ____

WORKMAN'S COMP

WC Insurance Carrier: ______________________ Employer: _______________ Phone: ______________
Date of Injury: ______________ Authorized By: ________________________ Claim # ________________

MRI SCREENING QUESTIONS: (CHECK IF APPLIES)

Aneurysm Clips	Neurostimulator	Patient's Weight	Lens Implants (date)
Stents	Pacemaker/Wiring	Claustrophobic	Heart Valve Prosthesis
Shrapnel or Bullets	Metal Grinding/Welding	Brain Surgery (date)	Internal Hearing Aid
Ear Implants	Biostimulator	Head Tumor or Trauma	

CT OR IVP QUESTIONS: (CHECK IF APPLIES) IF YES TO ANY OF THESE QUESTIONS BUN AND CREATININE IS NEEDED

Diabetic	Hypertension
Glucophage Glucovance	Multiple Myeloma
Metformin Other_______	Renal Insufficiency/Single Kidney
Iodine Allergy	Age>60 if a patient is over 60, BUN & Creatinine is needed w/in 6 months prior to exam

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 (Check Box if No)*

Ordering Physician: ___________________________ Contact Person: ___________________________

Physician Signature: ___________________________ Phone: _______________ Fax: ______________
Physician to CC: ___________________________

RDC Scheduling Only: *Scheduler _________ Location____________ Appt Date/Time____________ Check-in_________*
Spoke w/ Patient_____________ Left Message___________ Call Attempt Failed, Office to Try_____________