# CHIROPRACTIC ORDER FORM

**SCHEDULING**
P: 920.996.0724
F: 920.996.0728

O Patient will call to schedule
O Call patient to schedule

**CHIROPRACTIC RADIOLOGIST CONSULTATION HOTLINE**
P: 888.541.SCAN (7226)

**ORDER ONLINE**
insideRAYUS.com

O Appleton
O Appleton Darboy
*See back for addresses*

RAYUS RADIOLOGY™

| Appointment date and time | Check-in time | Patient DOB | O M O F | Weight |
|---|---|---|---|---|
| Patient name (as shown on insurance card) | Primary phone # | Secondary phone # | | |
| Address | City | State | Zip | |

**Bring complete insurance information to appointment**

| Insurance name | Insurance ID # | Group # |
|---|---|---|
| O Auto O Workers' comp O Commercial/Private / Date of injury | Pre-authorization/Pre-certification # | |

**(REQUIRED) Written diagnosis/reason/symptom for exam(s).** Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

**Is the exam/procedure related to an injury?** O No O Yes **If yes** O Initial O Subsequent or O Sequela

## MRI

**O Without contrast O With and without contrast O Contrast as clinically indicated based on imaging protocol**

**Patient pain (check all that apply)** O Acute O Chronic O Right O Left O Bilateral O Anterior O Posterior Duration _____

**Previous MRI?** O No O Yes Where _____

**Previous surgery on area to be scanned?** O No O Yes

**If lumbar spine, would you like weight-bearing?** O No O Yes

**Special instructions (check all that apply)**

- O Allergic to contrast agents
- O Aneurysm clip
- O Any metal in body
- O History of metal in eyes
  - O Orbit imaging needed
- O Blood thinners
- O Brain or heart surgery
- O Cardiac pacemaker
- O Chemotherapy
- O Claustrophobic
- O Diabetes
- O Infusion device
- O Interpreter needed
  - Language: _____
- O Neurostimulators
- O Pregnancy
- O Renal failure/dialysis
- O Surgery in the last 6 weeks
- O Transportation required
- O Weight consideration

MRI spine interpretations will be performed by a subspecialized MD spine radiologist and Dr. Tim Mick, DC, DACBR, FICC or Dr. Stephen Fridinger, DC, DACBR.
If you prefer, you may request:
O MD read only

**Lab results*** Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed
**Lab values needed within 30 days of the exam for IV contrast if the patient 1) is diabetic, 2) is 60 years or older, 3) has a history of renal failure or renal disease 4) is having chemotherapy or 5) has only one kidney.*

**REPORTING METHOD** O Deliver CD/Images O CD/Images w/patient O Report ONLY O STAT O Read and call ASAP _____

| Area to be scanned | | | |
|---|---|---|---|
| Provider name (print) | Phone # | | Fax # |
| Address | City | State | Zip code |
| **Provider signature (required)** Do not use rubber stamp. | **NPI # (required for new providers)** | Date | Contact # |

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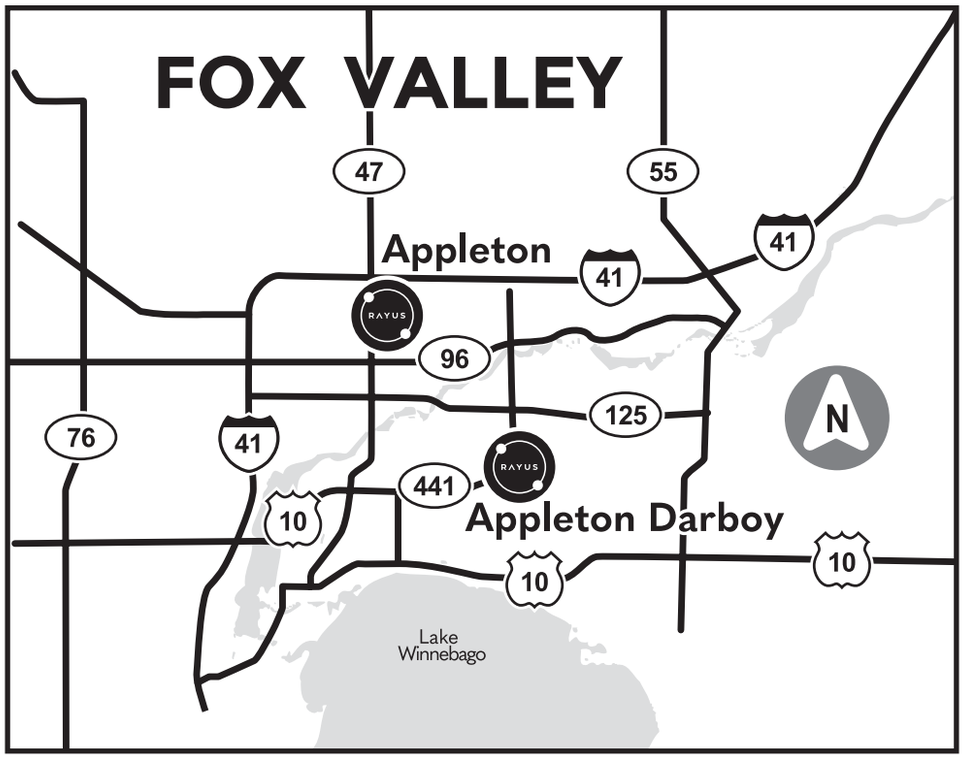


**APPLETON**
201 W. Northland Ave., Suite A
Appleton, WI 54911

- High-field MRI
- High-field open MRI

**APPLETON DARBOY**
3525 Calumet St., Suite 1500
Appleton, WI 54915

- High-field MRI

**For directions, visit RAYUSradiology.com.**