

SCHEDULING

- Patient will call to schedule
- Call patient to schedule

Evening and weekend hours available

○ ALEXANDRIA

A service of Alomere Health
 P: 320.762.6040
 F: 320.762.6038
 E: alexorders@RAYUSradiology.com

RADIOLOGIST CONSULTATION
 P: 320.762.6040

INSURANCE SPECIALIST

P: 320.762.6059
 See back for addresses

○ SARTELL

○ ST. CLOUD NORTHWEST
○ ST. CLOUD SOUTH
 P: 320.251.0609
 F: 320.251.3806
 E: RAYUSstcsched@RAYUSradiology.com

RADIOLOGIST CONSULTATION

P: 320.251.0609 press 7
INSURANCE SPECIALIST
 P: 320.229.4603



Appointment date and time		Check-in time	Patient DOB	<input type="radio"/> M <input type="radio"/> F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #	
Referring clinic patient ID/MRN #		Authorization #/Auth. ins. phone #	Insurance ID #	
<input type="radio"/> Auto	<input type="radio"/> Workers' comp	<input type="radio"/> Commercial/Private	<input type="radio"/> Claustrophobic	Date of injury
			<input type="radio"/> Needs assistance	Attorney name/claim #
(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.			Clinical Decision Support (CDS)	
			Required for Medicare Part B	
			Modifier (determination)	G-code (vendor)
Is the exam/procedure related to an injury? <input type="radio"/> No <input type="radio"/> Yes If yes <input type="radio"/> Initial <input type="radio"/> Subsequent or <input type="radio"/> Sequela				
Area of body				<input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL

MRI

IV contrast as clinically indicated by radiologist
 OR No contrast

Sedation for
 Pain Claustrophobia

Arthrogram _____
 Angiogram _____
 Pre MRI orbit, X-ray (for metal)

ULTRASOUND

Doppler if clinically indicated by radiologist
 OR No Doppler

If ordering a Pelvis or OB please select one:

Transvaginal study if clinically indicated by radiologist OR No transvaginal

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

Spine injection consultation with radiologist

- Epidural steroid injection/Epidurography
- Nerve root block
- SI joint injection
- Facet joint
- Myelogram
- Discogram
- Bone marrow aspirate concentrate (BMAC)
- Vertebral augmentation
- Sympathetic block
- Kyphoplasty
- Arthrogram (Joint/MSK)
- Platelet rich plasma (PRP)
- Medial branch block (MBB)
- Genicular knee
- Other _____

CT

IV contrast as clinically indicated by radiologist
 OR No contrast

3D reconstructions as clinically indicated by radiologist OR No 3D reconstructions

Sedation

Arthrogram _____
 Angiogram _____

X-RAY/FLUOROSCOPY

Procedure _____
 Views _____

BREAST IMAGING SERVICES

- 3D screening mammogram
- 3D diagnostic mammogram
- 2D screening mammogram
- 2D diagnostic mammogram
- Ultrasound
- Biopsy
 - Stereotactic
 - US-guided
 - MRI-guided
- MRI bilateral

L R BIL
 L R BIL
 L R BIL
 L R BIL
 L R BIL
 L R BIL

NUCLEAR MEDICINE

Alexandria only

- Bone scan - specify _____
 - Whole
 - 3-phase
 - SPECT
 - Limited
- Gastrointestinal
- Hepatobiliary/GB
- Liver or spleen
- Lung
- Muga
- Renal
- Sentinal node
- Thallium/Cardiolite
- Thyroid
- Other _____

PAIN CARE

Sartell only

Comprehensive pain care evaluation by pain care provider

Notes _____

PET/CT

Alexandria only

- Restaging
- Initial treatment
- Eyes to thighs
- Whole body

Previous treatments/imaging/exams No Yes What type _____

Lab results Creatinine _____ Blood draw date _____ 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 having chemotherapy 3) has lupus or 4) has renal impairment

REPORTING METHOD

Routine Read and call _____ STAT/ASAP

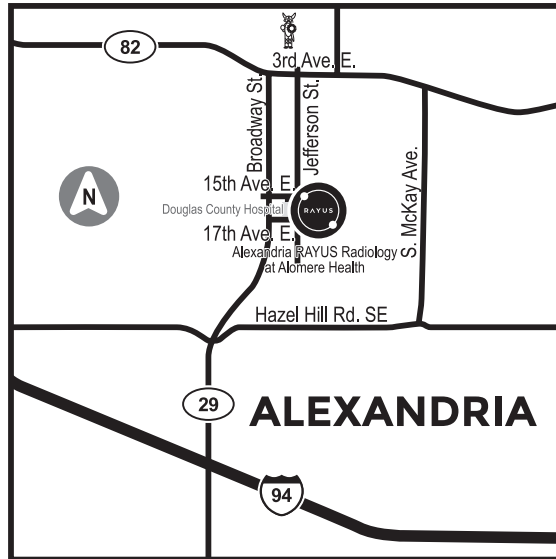
Hold and call _____ Patient to hand carry films/CD/report Next-day follow-up

Provider name (print) _____ Provider location _____ City/Zip _____ Phone # _____

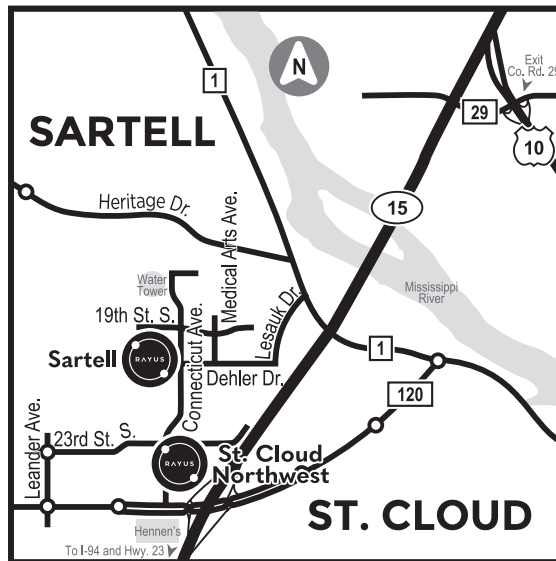
Provider signature (required) _____ Date (required) _____ Time (required) _____ am pm _____ NPI # (required for new providers) _____

Do not use rubber stamp. Electronically signed

ALEXANDRIA
 A service of Alomere Health
 111 17th Ave. E.
 Alexandria, MN 56308
alexorders@RAYUSradiology.com



SARTELL
 1901 Connecticut Ave. S., Suite 200
 Sartell, MN 56377
RAYUSstcsched@RAYUSradiology.com



ST. CLOUD NORTHWEST
 251 County Rd. 120, Suite D
 St. Cloud, MN 56303
RAYUSstcsched@RAYUSradiology.com

ST. CLOUD SOUTH
 1301 33rd St. S., Suite 100
 St. Cloud, MN 56301
RAYUSstcsched@RAYUSradiology.com

