

WOMEN'S IMAGING ORDER FORM

SCHEDULING

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 E: TXimagingorders@RAYUSradiology.com
 Tax ID #46-5265469
 NPI #1164829214

DESOTO

1750 N. Hampton Rd.
 DeSoto, TX 75115

- Patient will call to schedule
 Call patient to schedule



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 #	
Insurance name	Insurance ID #	Group #	
(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 (MRI only)		
	Modifier (determination)	G-code (vendor)	

BILATERAL BREAST MRI

IV contrast as clinically indicated by radiologist OR No contrast

- Screening
 Diagnostic
 Implant rupture evaluation

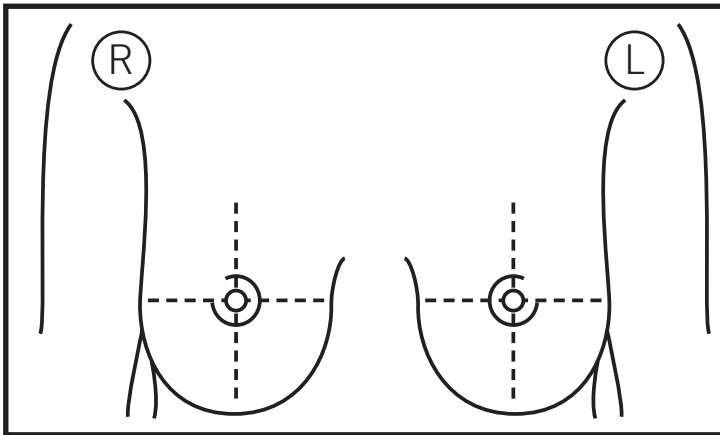
BREAST ULTRASOUND

L OR BIL

Proceed at radiologist discretion, if indicated.

MAMMOGRAPHY

- Screening (asymptomatic patient)
 Diagnostic (symptomatic patient or follow-up to abnormal screening)
Appointment and order required for diagnostic mammogram
 L R BIL
 3D



Please mark abnormalities on diagram.

IMAGE-GUIDED BREAST PROCEDURES

L OR BIL

- Galactogram
 MRI-guided breast biopsy
 Needle localization
 Stereotactic biopsy
 US-guided core biopsy
 US-guided cyst aspiration
 Other _____

ULTRASOUND

Transvaginal if clinically indicated by radiologist OR No transvaginal

- Abdomen complete
 Obstetric
 1st trimester
 2nd trimester
 3rd trimester
 Pelvis
 Thyroid
 Transvaginal
 Other _____

BONE DENSITY

- Screening or Diagnostic
 • History of pathological fracture? No Yes
 • Age-related osteoporosis w/o current pathological fracture? No Yes
 • Estrogen deficiency/clinical risk for osteoporosis? No Yes
 • Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids?
 No Yes

SPECIAL PROCEDURES

- Uterine fibroid embolization consult

Does this patient have breast implants? <input type="radio"/> No <input type="radio"/> Yes			
Where was previous mammogram performed? _____			Date _____
Patient considerations (check all that apply) <input type="radio"/> Sedation (administered by RAYUS Radiology) All patients receiving sedation require a driver.			
Provider name (print)	Provider location City/Zip	Phone #	Fax #
Provider signature (required) Do not use rubber stamp.	NPI # (required for new providers)	Date	