X-RAY ORDER FORM

SCHEDULING
P: 615.890.8999
F: 615.890.6053
E: TNRAYUSorders@RAYUSradiology.com

O MURFREESBORO
1001 N. Highland Ave.
Murfreesboro, TN 37130

O SMYRNA
537 Stonecrest Pkwy., Suite 102
Smyrna, TN 37167

PATIENTS
Bring this form with you to your exam.

PRE-REGISTER
myExamAnswers.com
Tax ID #81-5457003

CDI IS NOW RAYUS RADIOLOGY™

O Patient will call to schedule O Call patient to schedule O Walk-in appointment

Appointment date and time	Check-in time	Patient DOB	O M O F	O Auto O Workers' Comp O Commercial/Private
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #	Date of injury	
Insurance name	Insurance ID #	Group #	Pre-authorization #	

(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.

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

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

X-RAY

Weight limit up to 800 lbs. ●L ●R ●BIL

Views _____

O Abdomen - KUB
O Abdomen - flat & upright w/chest
O Ankle
O Cervical spine
O Complete
O Flex & extension
O Chest PA/Lateral
O Clavicle
O Elbow
O Eye
O Facial bones
O Femur
O Finger(s) - specify _____
O Foot
O Forearm
O Hand
O Heel
O Hip(s)
O Humerus
O Knee
O Lumbar spine
O Complete
O Flex & extension
O AP & LAT
O Orbits
O Pelvis
O Ribs w/chest
O Sacrum/Coccyx
O Scoliosis series
O Shoulder
O SI joints
O Sinus
O Complete
O Waters
O Skull
O Thoracic spine, 3-view
O Tibia/Fibula
O Wrist
O Other _____

BREAST IMAGING

O Screening mammogram

Previous treatments/imaging/exams O No O Yes What type _____
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed*
**Lab values may be needed within 30 days of the exam for IV contrast if the patient: 1) is diabetic, 2) is 60 years or older, 3) is on chemotherapy or 4) has only one kidney.*

REPORTING METHOD
O Fax report to _____ O Call STAT to _____
O Hold patient and call _____ O Send films/disc with patient

Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date