CHIROPRACTIC ORDER FORM

SCHEDULING
P: 503.253.1105
F: 503.535.8394
E: ORRAYUSorders@RAYUSradiology.com

O Bethany
O Gateway
O Hall/Nimbus
O Happy Valley
O Slabtown
See back for addresses

O Patient will call to schedule
O Call patient to schedule

RAYUS RADIOLOGY™

Appointment date and time	Check-in time	Patient DOB	Sex assigned at birth O M O F
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #	
Insurance name	Insurance ID #	Authorization #	
O Auto O Workers' comp O Commercial/Private O No insurance	Date of injury	Claim #	Attorney name

(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

If you prefer, you may request: ● MD read only OR ● Chiropractic read

X-RAY

SPINE
O Cervical spine (AP, APOM, Lat)
  Additional views:
  O Flex/Ext
  O Obliques
  O APOM R/L lateral bending
  O AP, APOM, lat, flex, ext, obliques (Davis series)
O Thoracic spine (AP, lat)
  Additional views:
  O AP, lat, swimmers
O Lumbar spine (AP/PA, lat)
  O AP/PA, lat
  O Lat L/S spot
  O Axial L/S spot
  O Obliques
  O Flex/Ext
  O R/L lateral bending
O Sacrum/Coccyx
  O AP, lat
O Scoliosis assessment
  O AP, lat, T/L (thoracolumbar)
O Other spine views
(specify) _____

UPPER EXTREMITY
O Shoulder O R O L
  O AP with int/ext rotation
  O Grashey
  O Transaxial
  O 'Y' view
O Clavicle O R O L
O Acromioclavicular joint O R O L
  O With and without weight-bearing
O Elbow O R O L
  O AP, lat
  O Radial head
O Wrist O R O L
  O PA, lat, obl
  O Scaphoid
O Hand O R O L
  O PA, lat, obl

LOWER EXTREMITY
O Pelvis
  O AP
O Hip O R O L
  O AP pelvis/frog leg lateral
O Knee O R O L
  O AP, lat
  O Tunnel
  O Sunrise
  O PA/Rosenberg
O Ankle O R O L
  O AP, lat, obl
O Foot O R O L
  O AP, lat, obl

CHEST/THORAX IMAGING
O Chest
O PA, lat O PA
O Ribs O R O L
  O Upper AP or PA, obl, PA chest
  O Lower AP or PA, obl, PA chest

OSTEOPOROSIS SCREENING

DXA/BMD SCAN
O Screening or O Diagnostic
- History of pathological fracture? O No O Yes
- Age-related osteoporosis w/o current pathological fracture? O No O Yes
- Estrogen deficiency/clinical risk for osteoporosis? O No O Yes
- Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids? O No O Yes
- Including vertebral fracture assessment (*Gateway only*) O No O Yes

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast

O Angiogram
O Arthrogram (joint injection) - Specify _____

SPINE
O Cervical
O Thoracic
O Lumbar

UPPER EXTREMITY
O Shoulder O R O L O BIL

LOWER EXTREMITY
O Hip O R O L O BIL
O Knee O R O L O BIL
O Ankle O R O L O BIL

O Extremity (specify) _____
O Other _____

CT

O IV contrast as clinically indicated by radiologist OR O No contrast
O 3D reconstructions as clinically indicated by radiologist OR O No reconstructions

O Leg length study
O Spine (specify) _____
O Extremity (specify) _____
O Other _____

OTHER

_____
_____
_____

Previous treatments/imaging/exams O No O Yes What type _____
Patient considerations (check all that apply) O Requires transportation O Allergies to contrast agents O Diabetes O Weight consideration O Claustrophobic
O Interpreter needed (language) _____ O Renal failure/dialysis O Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
O Other _____
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed

REPORTING METHOD

O Routine
O Hold and call _____
O Read and call _____
O Patient to hand carry films/CD/report
O STAT/ASAP
O Next-day follow-up

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

SCHEDULING
P: 503.253.1105
F: 503.535.8394
E: ORRAYUSorders@RAYUSradiology.com

RAYUS RADIOLOGY™

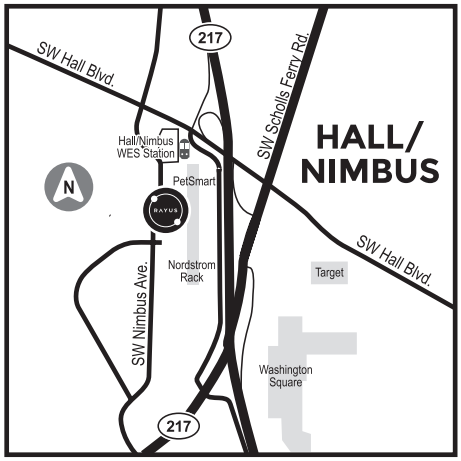
PATIENT PREPARATION

ARTHROGRAM • DXA SCAN
No preparation is necessary.

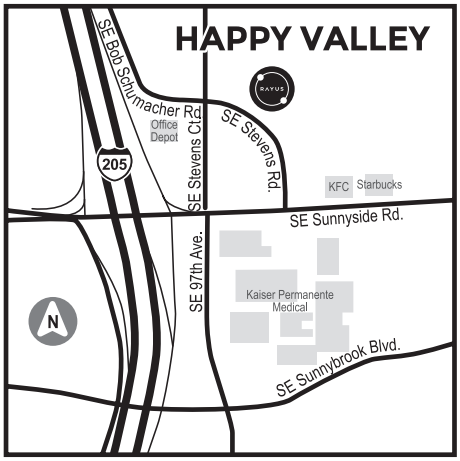
CT • MRI
Bring prior MRI, CT or X-ray films. Call for instructions: 503.253.1105

BETHANY
1500 NW Bethany Blvd.
Suite 100
Beaverton, OR 97006

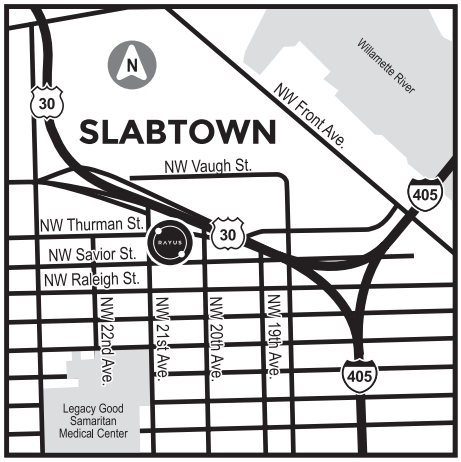
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



HALL/NIMBUS
8950 SW Nimbus Ave.
Beaverton, OR 97008



HAPPY VALLEY
10121 SE Sunnyside Rd.
Suite 170
Clackamas, OR 97015



SLABTOWN
2055 NW Savier St.
Suite 110
Portland, OR 97209