CHIROPRACTIC ORDER FORM

INSIGHT IMAGING IS NOW RAYUS RADIOLOGY™

SCHEDULING
P: 540.581.0882
F: 540.581.0881
E: ROAorders@RAYUSradiology.com
See back for address

O Patient will call to schedule
O Call patient to schedule

TAX ID: 272510062
NPI: 1831404284

If unable to keep appointment, please contact us 24 hours in advance.

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

Area of body	O Cervical O Thoracic O Lumbar	O R O L O BIL

MRI

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

O High-field MRI
O High-field open MRI
O Angiogram
O Arthrogram (joint injection)

CT

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

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

ULTRASOUND

O Doppler as clinically indicated by radiologist
OR O No Doppler

X-RAY

Views _____
O Standard _____
O Additional _____

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

O Diagnostic and therapeutic injection consultation

Pain/Numbness
- Location _____
- Radiation _____
- Intensity _____
- Chronicity _____

Other relavant symptoms _____

Relevant physical exam findings _____

Known related, or relevant medical or surgical history _____

Current medications _____

Known drug allergies _____

Known relevant laboratory results _____

Known or suspected contraindications to needle-type procedure, steroid medications, local anesthetics (bleeding risk) _____

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 Other _____
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed

REPORTING METHOD O Patient to hand carry films/CD O Read and fax _____

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

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ROANOKE
2923 Franklin Rd. SW
Roanoke, VA 24014

FROM INTERSTATE 81: Take exit 143, which is Interstate 581. From Interstate 581 look for exit Wonju to Franklin Rd. There is no exit number. Continue on Wonju to the bottom of the hill and turn right onto Franklin Rd. Continue on Franklin Rd. RAYUS Radiology is located on the right.

FROM 220: Take the Franklin Rd. exit from 220N and turn right toward downtown Roanoke. Continue down Franklin Rd. for approximately one mile. RAYUS Radiology is located on the left.