SCHEDULING
O Patient will call to schedule
O Call patient to schedule
Evening and weekend hours available

O 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

O SARTELL
O ST. CLOUD NORTHWEST
O 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	Sex assigned at birth O M O F
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #	
Referring clinic patient ID/MRN #	Authorization #/Auth. ins. phone #	Insurance ID #	

O Auto O Workers' comp O Commercial/Private | O Claustrophobic O Needs assistance | Date of injury | 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.

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)

Area of body O L O R O BIL

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast
Sedation for
O Pain O Claustrophobia
O Arthrogram ______
O Angiogram ______
O Pre MRI orbit, X-ray (for metal)

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
O Sedation
O Arthrogram ______
O Angiogram ______

PAIN CARE

Sartell only
O Comprehensive pain care evaluation by pain care provider
Notes ______

PET/CT

Alexandria only
O Restaging
O Initial treatment
O Eyes to thighs
O Whole body

ULTRASOUND

O Doppler if clinically indicated by radiologist OR O No Doppler

If ordering a Pelvis or OB please select one:
O Transvaginal study if clinically indicated by radiologist OR O No transvaginal

X-RAY/FLUOROSCOPY

O Procedure ______
O Views ______

BREAST IMAGING SERVICES

O 3D screening mammogram O L O R O BIL
O 3D diagnostic mammogram O L O R O BIL
O 2D screening mammogram O L O R O BIL
O 2D diagnostic mammogram O L O R O BIL
O Ultrasound O L O R O BIL
O Biopsy O L O R O BIL
  O Stereotactic
  O US-guided
  O MRI-guided
O MRI bilateral

BONE DENSITY

O Screening 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
- **Patient has been diagnosed with primary hyperparathyroidism?** O No O Yes

O Body composition assessment

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

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

NUCLEAR MEDICINE

Alexandria only
O Bone scan - specify ______
  O Whole
  O 3-phase
  O SPECT
  O Limited
O Gastrointestinal
O Hepatobiliary/GB
O Liver or spleen
O Lung
O MUGA
O Renal
O Sential node
O Thallium/Cardiolite
O Thyroid
O Other ______

Previous treatments/imaging/exams O No O Yes What type ______
Lab results Creatinine ______ Blood draw date ______ O 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
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.	**Date (required)**	**Time (required)** am pm	**NPI # (required for new providers)**

RAYUS RADIOLOGY™

ALEXANDRIA
A service of Alomere Health
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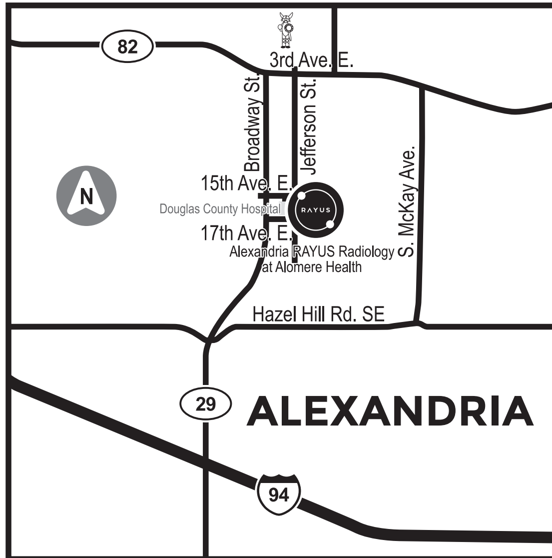
Alexandria, MN 56308
alexorders@RAYUSradiology.com



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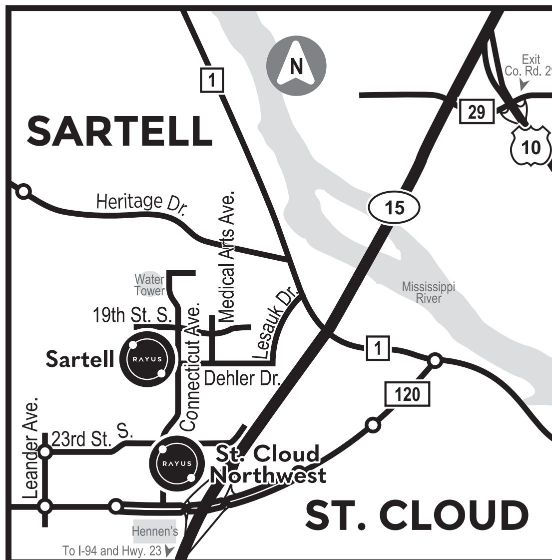

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