# CHIROPRACTIC ORDER FORM

**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

**O SARTELL**
**O ST. CLOUD NORTHWEST**
**O ST. CLOUD SOUTH**
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**RADIOLOGIST CONSULTATION**
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**INSURANCE SPECIALIST**
P: 320.229.4603

RAYUS RADIOLOGY™

*See back for addresses*

| 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

Area of body | O L O R O BIL

## PAIN CARE

*Sartell only*

O Comprehensive pain care evaluation by a physiatrist or NP

Notes _____

## CT

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

Body part _____

## MRI

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

### NEURO
O Brain
Spine
O Cervical
O Thoracic
O Lumbar

### MSK
O Extremity (non-joint) _____
O L O R O BIL

O Joint _____
O L O R O Arthrogram (if indicated)

### OTHER
O _____

## DIAGNOSTIC AND THERAPEUTIC INJECTIONS

**O Therapeutic injection per radiologist discretion**
(May include any of these injections - up to 3)
- Epidurography/Epidural steroid injection
- Facet joint
- Nerve block
- SI joint

**O Area of injection**
O Cervical
O Thoracic
O Lumbar
Levels _____

**O Injection type**
O Therapeutic
O Diagnostic
O Both

## ULTRASOUND

**O Doppler if clinically indicated by radiologist OR O No Doppler**

Body part _____

## 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

## X-RAY

Views _____

Procedure/body part _____

**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)** |

**ALEXANDRIA**
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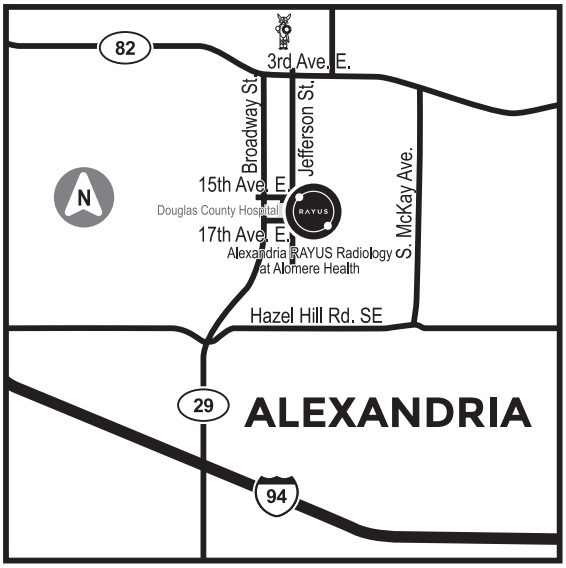


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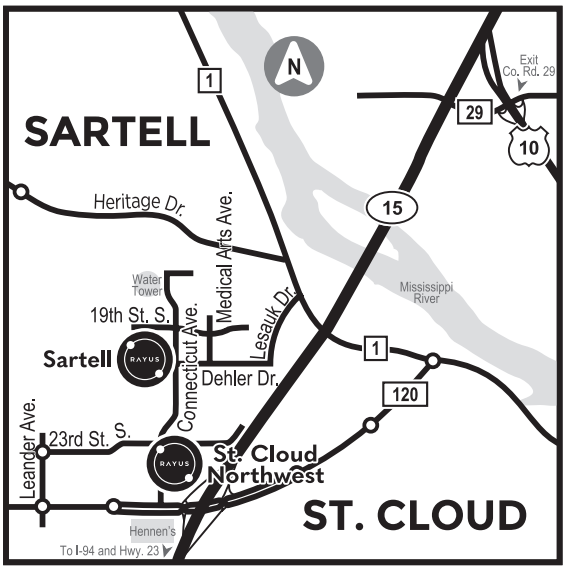


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