SCHEDULING
P: 920.996.0724
F: 920.996.0728

O Appleton
See back for address

O Patient will call to schedule
O Call patient to schedule

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Appointment date and time	Check-in time	Patient DOB	Sex assigned at birth O M O F	Weight

Patient name (as shown on insurance card)	Primary phone #	Secondary phone #

Address	City	State	Zip

Bring complete insurance information to appointment

Insurance name	Insurance ID #	Group #

O Auto O Workers' comp O Commercial/Private	Date of injury	Pre-authorization/Pre-certification #

(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)

MRI

O Without contrast O With and without contrast O Contrast as clinically indicated based on imaging protocol

Area to be scanned _____

Patient pain (check all that apply) O Acute O Chronic O Right O Left O Bilateral O Anterior O Posterior Duration _____

Previous MRI? O No O Yes Where _____

Previous surgery on area to be scanned? O No O Yes

If lumbar spine, would you like weight-bearing? O No O Yes

Special instructions (check all that apply)

- O Allergic to contrast agents
- O Aneurysm clip
- O Any metal in body
- O History of metal in eyes
  - O Orbit imaging needed
- O Blood thinners
- O Brain or heart surgery
- O Cardiac pacemaker
- O Chemotherapy
- O Claustrophobic
- O Diabetes
- O Infusion device
- O Interpreter needed
  Language: _____
- O Neurostimulators
- O Pregnancy
- O Renal failure/dialysis
- O Surgery in the last 6 weeks
- O Transportation required
- O Weight consideration

Lab results* Creatinine _____ BUN _____ 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 60 years or older, 3) has a history of renal failure or renal disease 4) is having chemotherapy or 5) has only one kidney.*

REPORTING METHOD O Deliver CD/Images O CD/Images w/patient O Report ONLY O STAT O Read and call ASAP _____

Provider name (print)	Phone #		Fax #

Address	City	State	Zip code

Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date	Contact #

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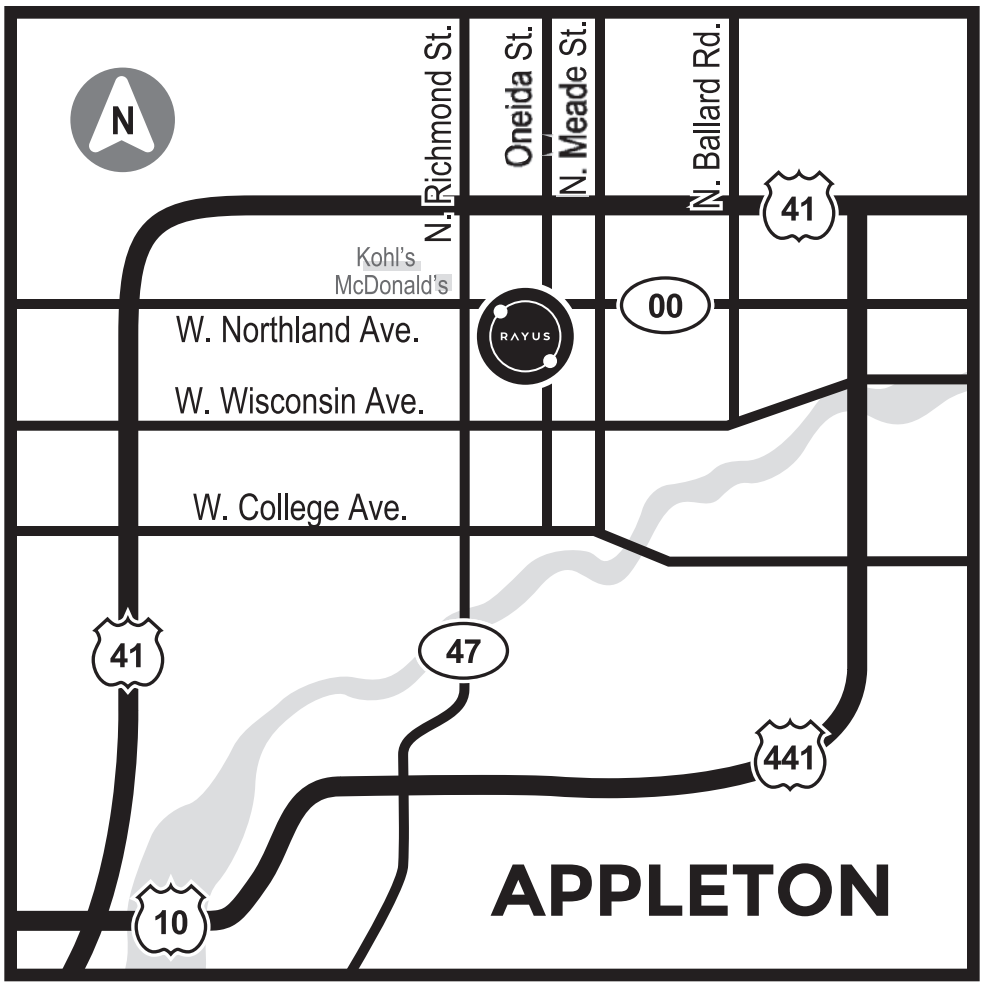

APPLETON
201 W. Northland Ave., Suite A
Appleton, WI 54911

- High-field MRI
- High-field open MRI

For directions, visit RAYUSradiology.com.