SCHEDULING
P: 920.996.0724
F: 920.996.0728

O Patient will call to schedule
O Call patient to schedule

O Appleton
See back for address

ORDER ONLINE
insideRAYUS.com

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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RAYUS RADIOLOGY™

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

- High-field MRI
- High-field open MRI

For directions, visit RAYUSradiology.com.