

CHIROPRACTIC ORDER FORM

SCHEDULING

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

○ 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

○ SARTELL

○ ST. CLOUD NORTHWEST

○ 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



See back for addresses

Appointment date and time		Check-in time	Patient DOB	Sex assigned at birth ○ M ○ F
Patient name (as shown on insurance card)		Primary phone #		Secondary phone #
Referring clinic patient ID/MRN #		Authorization #/Auth. ins. phone #		Insurance ID #
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	<input type="radio"/> Claustrophobic <input type="radio"/> 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? ☐ No ☐ Yes If yes ☐ Initial ☐ Subsequent or ☐ Sequela

Area of body ○ L ○ R ○ BIL

PAIN CARE		MRI	DIAGNOSTIC AND THERAPEUTIC INJECTIONS
Sartell only <input type="radio"/> Comprehensive pain care evaluation by a physiatrist or NP Notes _____ _____ _____	<input type="radio"/> IV contrast as clinically indicated by radiologist <input type="radio"/> No contrast <input type="radio"/> Sedation	NEURO <input type="radio"/> Brain <input type="radio"/> Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar MSK <input type="radio"/> Extremity (non-joint) _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Joint _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> Arthrogram (if indicated) OTHER <input type="radio"/> _____	<input type="radio"/> Therapeutic injection per radiologist discretion (May include any of these injections - up to 3) • Epidural steroid injection • Facet joint injection • Nerve block injection • SI joint injection <input type="radio"/> Area of injection <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar Levels _____ <input type="radio"/> Injection type <input type="radio"/> Therapeutic <input type="radio"/> Diagnostic
CT			ULTRASOUND
<input type="radio"/> IV contrast as clinically indicated by radiologist <input type="radio"/> No contrast 3D reconstructions as clinically indicated by radiologist <input type="radio"/> No 3D reconstructions Body part _____	<input type="radio"/> Doppler if clinically indicated by radiologist <input type="radio"/> No Doppler <input type="radio"/> Complete <input type="radio"/> Limited Body part _____	<input type="radio"/> Screening <input type="radio"/> Diagnostic • History of pathological fracture? <input type="radio"/> No <input type="radio"/> Yes • Age-related osteoporosis w/o current pathological fracture? <input type="radio"/> No <input type="radio"/> Yes • Estrogen deficiency/clinical risk for osteoporosis? <input type="radio"/> No <input type="radio"/> Yes • Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids? <input type="radio"/> No <input type="radio"/> Yes • Patient has been diagnosed with primary hyperparathyroidism? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Body composition assessment	X-RAY Views _____ Procedure/body part _____ _____ _____ _____

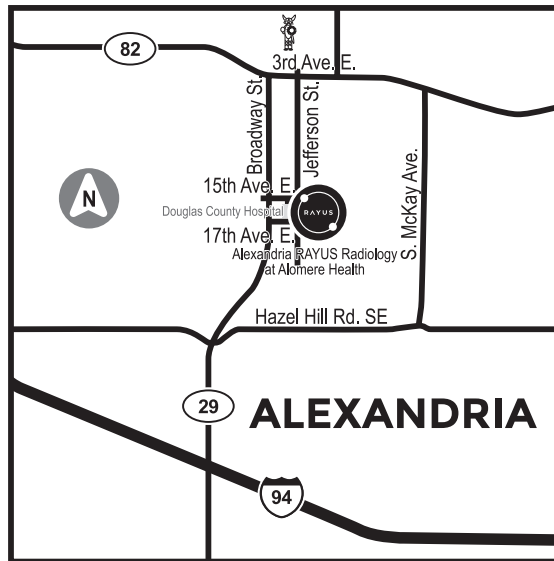
Previous treatments/imaging/exams <input type="radio"/> No <input type="radio"/> Yes If yes, what type _____			
Lab results Creatinine _____ Blood draw date _____		<input type="radio"/> On-site creatinine testing needed*	
*Lab values needed within 30 days of the exam for IV contrast if the patient 1) is diabetic, 2) is having chemotherapy 3) has lupus or 4) has renal impairment			
REPORTING METHOD <input type="radio"/> Routine <input type="radio"/> Read and call _____ <input type="radio"/> STAT/ASAP <input type="radio"/> Hold and call _____ <input type="radio"/> Patient to hand carry films/CD/report <input type="radio"/> 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

A service of Alomere Health
111 17th Ave. E.

Alexandria, MN 56308

alexorders@RAYUSradiology.com



SARTELL

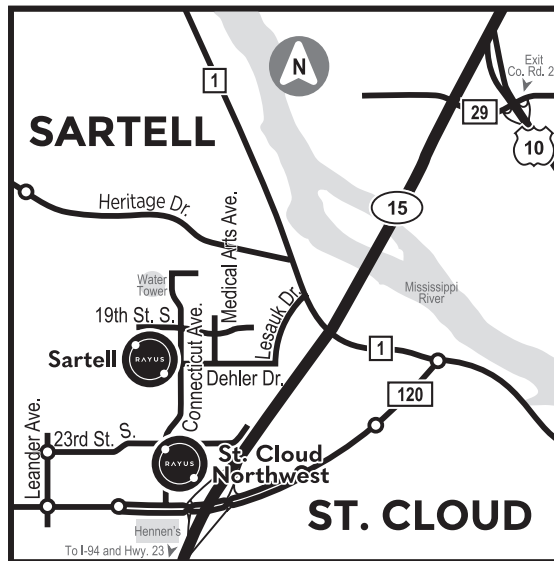
1901 Connecticut Ave. S., Suite 200
Sartell, MN 56377

RAYUSstcsched@RAYUSradiology.com

ST. CLOUD NORTHWEST

251 County Rd. 120, Suite D
St. Cloud, MN 56303

RAYUSstcsched@RAYUSradiology.com



ST. CLOUD SOUTH

3260 42nd Ave. S., Suite 101
St. Cloud, MN 56301

RAYUSstcsched@RAYUSradiology.com

