

SCHEDULING

Patient will call to schedule
 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 <input type="radio"/> M <input type="radio"/> 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.

**Clinical Decision Support (CDS)
Required for Medicare Part B**

Modifier (determination) G-code (vendor)

Is the exam/procedure related to an injury? No Yes **If yes** Initial Subsequent or Sequela

Area of body L R BIL

MRI

IV contrast as clinically indicated by radiologist
 No contrast
Sedation for
 Pain Claustrophobia

Arthrogram _____
 Angiogram _____
 Pre MRI orbit, X-ray (for metal)

CT

IV contrast as clinically indicated by radiologist
 No contrast
O3D reconstructions as clinically indicated by radiologist No 3D reconstructions
 Sedation

Arthrogram _____
 Angiogram _____

PAIN CARE

Sartell only

Comprehensive pain care evaluation by pain care provider

Notes _____

PET/CT

Alexandria only

Restaging
 Initial treatment
 Eyes to thighs
 Whole body
 Other _____

ULTRASOUND

Doppler if clinically indicated by radiologist
 No Doppler
 Complete Limited

If ordering a Pelvis or OB please select one:

Transvaginal study if clinically indicated by radiologist
 No transvaginal

X-RAY/FLUOROSCOPY

Procedure _____
 Views _____

BREAST IMAGING SERVICES

3D screening mammogram L R BIL
 3D diagnostic mammogram L R BIL
 2D screening mammogram L R BIL
 2D diagnostic mammogram L R BIL
 Ultrasound L R BIL
 Biopsy L R BIL

Stereotactic
 US-guided
 MRI-guided
 MRI bilateral

BONE DENSITY

Screening Diagnostic
• History of pathological fracture? No Yes
• Age-related osteoporosis w/o current pathological fracture?
 No Yes
• Estrogen deficiency/clinical risk for osteoporosis?
 No Yes
• Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids? No Yes
• Patient has been diagnosed with primary hyperparathyroidism?
 No Yes
 Body composition assessment

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

Spine injection consultation with radiologist
 L R BIL

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

NUCLEAR MEDICINE

Alexandria only

Bone scan - specify _____
 Whole
 3-phase
 SPECT
 Limited
 Gastrointestinal
 Hepatobiliary/GB
 Liver or spleen
 Lung
 MUGA
 Renal
 Sentinel node
 Thallium/Cardiolite
 Thyroid
 Other _____

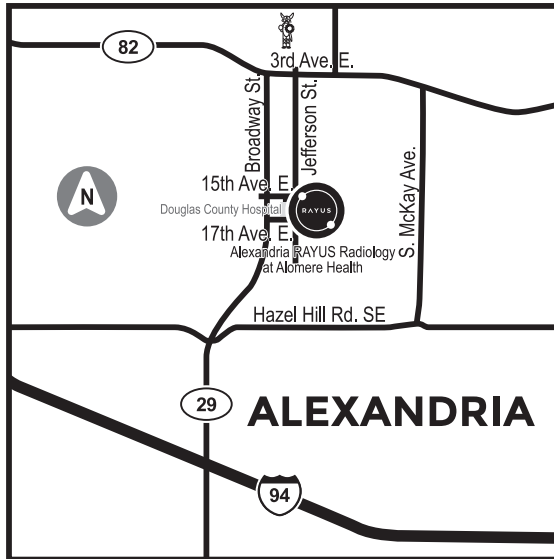
Previous treatments/imaging/exams No Yes If yes, what type _____

Lab results Creatinine _____ Blood draw date _____ 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

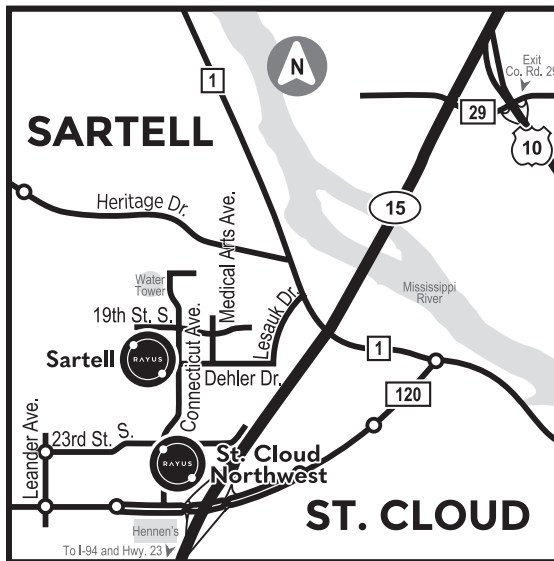
REPORTING METHOD Routine Read and call _____ STAT/ASAP
 Hold and call _____ Patient to hand carry films/CD/report Next-day follow-up

Provider name (print)	Provider location	City/Zip	Phone #
Provider signature (required) <i>Do not use rubber stamp</i>	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

