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
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

RAYUS RADIOLOGY™

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

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

Area of body O L O R O BIL

MRI

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

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

CT

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

O Arthrogram _____
O Angiogram _____

PAIN CARE

Sartell only

O Comprehensive pain care evaluation by pain care provider

Notes _____

PET/CT

Alexandria only

O Restaging
O Initial treatment
O Eyes to thighs
O Whole body
O Other _____

ULTRASOUND

O Doppler if clinically indicated by radiologist
O No Doppler
O Complete O Limited

If ordering a Pelvis or OB please select one:

O Transvaginal study if clinically indicated by radiologist
O No transvaginal

X-RAY/FLUOROSCOPY

O Procedure _____
O Views _____

BREAST IMAGING SERVICES

O 3D screening mammogram	O L O R O BIL
O 3D diagnostic mammogram	O L O R O BIL
O 2D screening mammogram	O L O R O BIL
O 2D diagnostic mammogram	O L O R O BIL
O Ultrasound	O L O R O BIL
O Biopsy	O L O R O BIL
O Stereotactic	
O US-guided	
O MRI-guided	
O MRI bilateral	

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

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

O Spine injection consultation with radiologist
O L O R O BIL

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

NUCLEAR MEDICINE

Alexandria only

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

Previous treatments/imaging/exams O No O Yes If 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
A service of Alomere Health
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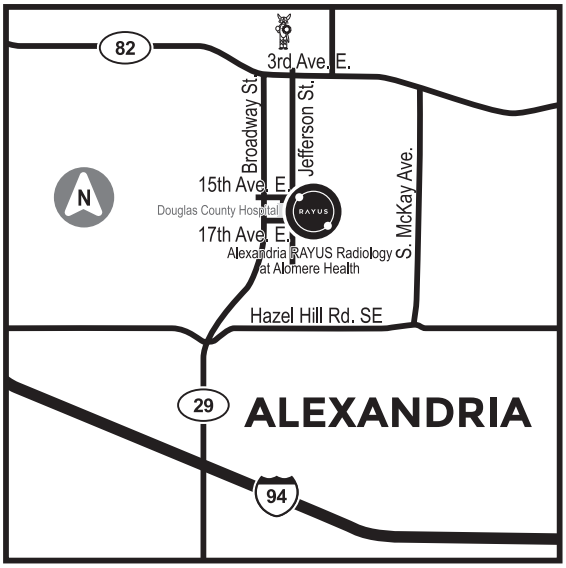
Alexandria, MN 56308
alexorders@RAYUSradiology.com



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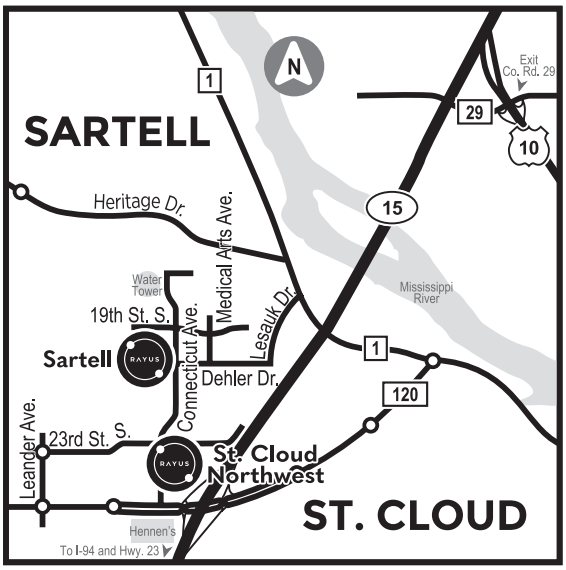

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