SCHEDULING
P: 503.253.1105
F: 503.535.8394
E: ORRAYUSorders@RAYUSradiology.com

O Bethany
O Gateway
O Hall/Nimbus
O Happy Valley
O Slabtown

See back for addresses

O Patient will call to schedule
O Call patient to schedule

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 #	
Insurance name	Insurance ID #	Authorization #	
O Auto O Workers' comp O Commercial/Private O No insurance	Date of injury	Claim #	Attorney name

(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

Area of body O R O L O BIL

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast

O Brain and/or O Orbits O Brain w/ MRA
Spine
O Cervical O Thoracic O Lumbar
O Upper cervical whiplash protocol
O Extremity _____
O Arthrogram _____
O X-ray orbits metal screening
O Other _____

CT

O IV contrast as clinically indicated by radiologist OR O No contrast

O Head
O Sinus O Maxillofacial
Dentascan
O Maxilla O Mandible
O Soft tissue neck
O Parathyroid
O Lung cancer screening - use Lung Screening pad
Spine
O Cervical O Thoracic O Lumbar
O Chest
O Calcium score screening
O Chest/Abdomen/Pelvis
O Abdomen
O Abdomen/Pelvis
O Pelvis
O Urogram (CT abdomen/CT pelvis)
O Stone protocol O KUB w/ & w/o
O Small bowel (abdomen/pelvis) (enterography protocol)
O Virtual colonoscopy
O Screening O Diagnostic
O Extremity _____
O Other _____

BREAST IMAGING

O L O R O BIL

O Mammogram
O Screening O Diagnostic
O **Proceed with additional diagnostic workup per radiologist's discretion (excludes MCR/MCD patients)**
O Bilateral breast MRI
O Ultrasound

BIOPSIES/ASPIRATIONS

O Image-guided core biopsy
O Core biopsy
O Fine needle aspiration
Body part _____
O Other _____

THERAPEUTIC PROCEDURES

O Image-guided joint injections
O Joint - specify _____
O Thoracentesis
O Paracentesis
O Other _____

X-RAY

Views _____

ULTRASOUND

O Abdomen O Complete O Limited _____
O Abdomen O w/Doppler liver study O w/Elastography
O Mesenteric
O Renal/Bladder O Renal Artery Doppler
O Bladder only
O Prostate
O Pelvic w/TV if indicated
O Follicular
O OB w/TV if indicated O <14 weeks O 14+ weeks
O Lower Ext O Venous O Arterial
O Upper Ext O Venous O Arterial
O ABI
O Thyroid
O Scrotal w/Doppler if indicated
O Soft tissue-location _____ O R O L O BIL
O Other _____

Order includes TV exam for all OB and pelvic orders, if clinically indicated. Order includes Doppler for all scrotal orders, if clinically indicated. Or opt out below.
☐ Mark this box to opt out of TV or Doppler.

FLUOROSCOPY

O Barium enema O w/ or O w/o air contrast
O Hysterosalpingogram
O Upper GI O w/ or O w/o small bowel series
O Barium swallow O w/ or O w/o upper GI
O Voiding cystourethrogram

DXA/BMD SCAN

O Screening or 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

O Body Composition Dexa

Prior studies O No O Yes Location of prior studies _____
Study read by O DACBR O MD radiologist
Patient consideration O Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed*
**Lab values may be needed within 30 days of the exam for IV contrast if the patient: 1) is diabetic, 2) is 60 years or older, 3) is on chemotherapy, 4) has history of kidney or liver disease or 5) has hypertension*

REPORTING METHOD O Report only O Report & images O Report & CD O Phone report _____ O Fax report _____

Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date