SCHEDULING
- ○ Call patient to schedule
- ○ Obtain authorization

If faxing an order, please include:
- Demographics
- Insurance card
- Clinical notes

RAYUS RADIOLOGY®

○ AUBURN
600 Turner Street, Suite 1
Auburn, Maine 04210
P: 800.734.4132
F: 207.470.1026

○ BRUNSWICK
1 Admiral Fitch Ave., Suite A
Brunswick, ME 04011
P: 800.734.4132
F: 207.721.8125

○ SCARBOROUGH
400 Technology Way, Suite A
Scarborough, Maine 04074
P: 207.883.3803
F: 207.883.6370

○ PORTLAND
33 Sewall St.
Portland, ME 04102
P: 207.828.2160
F: 207.828.2167

○ SKOWHEGAN
46 Fairview Ave.
Skowhegan, ME 04976
P: 800.734.4132
F: 207.883.6348

○ WESTBROOK
11 Rock Row, Suite 1A
Westbrook, ME 04092
P: 207.289.3100
F: 207.512.1205

Appointment date and time		Patient DOB		Sex assigned at birth ○ M ○ F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #	
Insurance name		Insurance ID #	Authorization #	
○ Auto ○ Workers' comp ○ Commercial/Private	Date of injury	Patient height	Patient weight	

(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

MRI

○ IV contrast as clinically indicated by radiologist OR ○ No contrast
○ L ○ R ○ BIL

NEURO
- ○ Brain ○ Orbits
- ○ IAC
- ○ Pituitary
- ○ Neck (soft tissue)

Spine
- ○ Cervical
- ○ Thoracic
- ○ Lumbar

BODY
- ○ Chest
- ○ Breast
- ○ Abdomen
- ○ Pelvis
- ○ MRCP w/3D reconstruction

MSK UPPER EXTREMITY
- ○ Elbow
- ○ Finger
- ○ Forearm
- ○ Hand
- ○ Humerus
- ○ Shoulder
- ○ Wrist

MSK LOWER EXTREMITY
- ○ Ankle
- ○ Foot
- ○ Hips
- ○ Pelvis
- ○ Knee
- ○ Pelvis/GYN - specify _____
- ○ Tibia/Fibula

MRA
- ○ Brain
- ○ Neck/Carotids
- ○ Renal arteries
- ○ Abdomen (aorta)
- ○ Upper extremity _____
- ○ Lower extremity _____
- ○ Other _____

OTHER
Area of body _____
- ○ Arthrogram (joint injection)
- ○ X-ray to rule out metal
- ○ _____

X-RAY

(Auburn, Brunswick and Westbrook locations only)

Views _____

CT

(Auburn, Brunswick, Scarborough and Westbrook locations only)

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

○ 3D reconstructions as clinically indicated by radiologist OR ○ No 3D reconstructions

○ L ○ R ○ BIL

NEURO
- ○ Brain ○ Orbits
- ○ Facial bones
  - ○ Maxilla
  - ○ Mandible
- ○ Sinus
- ○ IAC/Temporal bones
- ○ Neck (soft tissue)

Spine
- ○ Cervical
- ○ Thoracic
- ○ Lumbar

BODY
- ○ Chest
- ○ Abdomen
- ○ Abdomen & pelvis
  - ○ Urogram (IVP)
  - ○ Enterography
  - ○ Kidney stone protocol

MSK
- ○ Extremity _____

CTA
- ○ Brain
- ○ Neck/Carotids
- ○ Chest to rule out:
  - ○ Aneurysm
  - ○ Pulmonary embolism
- ○ Aorta-iliac runoff
- ○ Abdomen
- ○ Abdomen/pelvis
- ○ Other

OTHER
- ○ _____

ULTRASOUND

(Brunswick and Westbrook locations only)

Type _____

○ Doppler if clinically indicated by radiologist OR ○ No Doppler

If ordering a Pelvis or OB please select one:

○ Transvaginal study if clinically indicated by radiologist OR ○ No transvaginal

NUCLEAR MEDICINE

(Westbrook location only)
- ○ Bone scan _____
- ○ Hepatobiliary*
- ○ Renal
- ○ Other _____

**Only if patient does not need morphine to fill the gallbladder.*

BONE DENSITY

(Westbrook location only)
- ○ 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
- ○ Body composition assessment

QCT
- ○ QCT
  Height _____ Weight _____

BREAST IMAGING SERVICES

(Westbrook location only)

○ L ○ R ○ BIL
- ○ 3D tomosynthesis mammogram
  - ○ Screening ○ Diagnostic
  - ○ Proceed with diagnostic workup per radiologist's discretion (Medicare requires new orders for US, MR, Bx/asp)
- ○ Ultrasound
- ○ Biopsy
  - ○ Stereotactic ○ US-guided ○ MRI-guided
- ○ MRI

REPORTING METHOD

○ STAT/ASAP ○ STAT: Call report _____

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