

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 EAST

SARTELL WEST
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 <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.

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

Area of body	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL
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PAIN CARE

Sartell only

Comprehensive pain care evaluation by a physiatrist or NP

Notes _____

CT

IV contrast as clinically indicated by radiologist
 No contrast

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

Body part _____

PET/CT

- Indicate (re: cancer)
- History of, or Current
- Eyes to thighs
- Whole body
- Other _____

ULTRASOUND

Doppler if clinically indicated by radiologist
 No Doppler
 Complete Limited

Body part _____

MRI

IV contrast as clinically indicated by radiologist
 No contrast
 Sedation

NEURO

- Brain
- Spine
 - Cervical
 - Thoracic
 - Lumbar

MSK

- Extremity (non-joint) _____
- L R BIL
- Joint _____
- L R Arthrogram (if indicated)

OTHER

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

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

Area of injection

- Cervical
- Thoracic
- Lumbar
- Levels _____

Injection type

- Therapeutic
- Diagnostic

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

X-RAY

Views _____

Procedure/body part _____

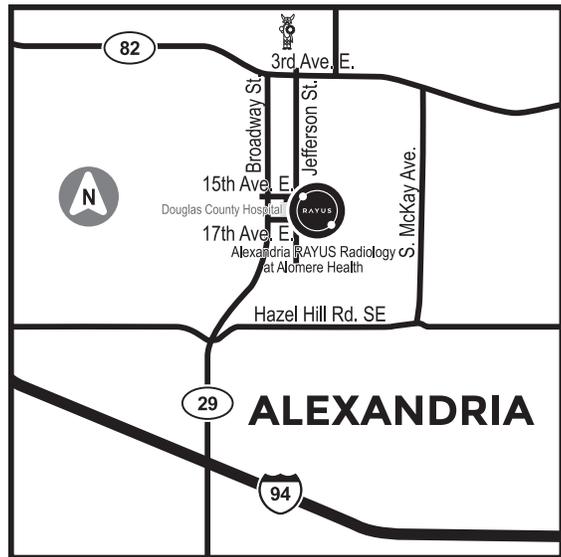
Previous treatments/imaging/exams <input type="radio"/> No <input type="radio"/> Yes If yes, what type _____	<input type="radio"/> On-site creatinine testing needed*
Lab results Creatinine _____ Blood draw date _____	
*Lab values needed within 30 days of the exam for IV contrast if the patient 1) is 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) <i>Do not use rubber stamp</i>	Date (required)	Time (required) am pm	NPI # (required for new providers)

ALEXANDRIA

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 Alexandria, MN 56308
alexorders@RAYUSradiology.com

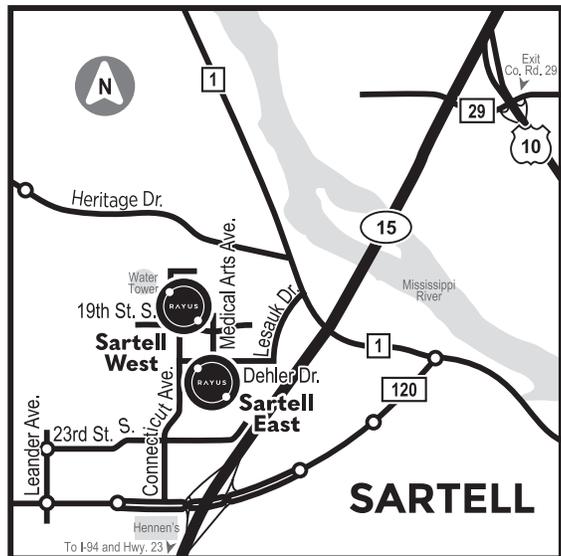


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