Important: Government-funded imaging scans require written orders.

SCHEDULING
P: 952.541.1840
F: 952.543.6524
E: TCorders@RAYUSradiology.com
See back for addresses

O Patient will call to schedule
O Call patient to schedule

INSURANCE SPECIALIST LINE
P: 952.541.1111

RADIOLOGIST CONSULTATION HOTLINE
P: 888.541.SCAN (7226)

O Blaine
O Burnsville
O Coon Rapids
O Eagan
O Eden Prairie
O Edina
O Highland Park
O Lakeville
O Maple Grove
O Maplewood
O North St. Paul
O Otsego
O Plymouth
O Roseville
O Shakopee
O St. Louis Park
O West St. Paul
O Woodbury

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 #	Group #	
O Auto O Workers' comp O Commercial/Private	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

(REQUIRED) Area of body O Cervical O Thoracic O Lumbar O R O L O BIL

MRI

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

O MRI
- O High-field MRI
- O 3T MRI
- O Open MRI
- O Angiogram
- O Arthrogram (joint injection)
- O Brain volumetric imaging

O OPEN UPRIGHT MRI
- O Flexion
- O Extension
- O Standing
- O Other _____

CT

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

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

X-RAY

Views _____

_____

_____

_____

PET/CT

Indicate (re: cancer)
O History of, or O Current
O Initial treatment
O Subsequent treatment
O Other _____

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

Arthrogram (joint/MSK):
O Diagnostic O Therapeutic
- O Bone marrow aspirate concentrate (BMAC)
- O Consultation for regenerative medicine (BMAC/PRP)
- O Discogram
- O Epidural steroid injection
- O Facet joint injection
- O Facet nerve injection/block
- O Nerve root block
- O Nucleoplasty
- O MBB (Medial Branch Block)
- O Myelogram
- O Platelet-rich plasma (PRP)
- O Rhizotomy (RF)
- O SI Joint
- O Spine Injection consultation with radiologist
- O Sympathetic block
- O Transforaminal epidural
- O Vertebral augmentation/Kyphoplasty
- O Vertebroplasty
- O Other _____

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

O Body composition assessment

QCT

O QCT
Height _____ Weight _____

ULTRASOUND

O Doppler if clinically indicated by radiologist OR O No Doppler

If ordering a Pelvis or OB please select one:

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

NUCLEAR MEDICINE

- O Bone scan _____
- O Brain/Brain SPECT
- O Gallium whole body
- O Other _____
- O Gastrointestinal
- O Hepatobiliary/GB
- O Liver or spleen
- O Lymphangiogram

VASCULAR CONSULTATIONS AND PROCEDURES

O RAYUS Vascular consultation to evaluate for:
- O Peripheral Artery Disease (PAD)/Critical limb ischemia (CLI)
- O Non-healing wound
- O Varicose veins
- O Pelvic congestion
- O Uterine fibroid embolization

O Other _____

BREAST IMAGING SERVICES

O 3D tomosynthesis mammogram
- O Screening O Diagnostic
- O Proceed with diagnostic workup per radiologist's discretion (Medicare requires new orders for US, MR, Bx/asp)

O Ultrasound
O Biopsy
- O Stereotactic O US-guided O MRI-guided

O MRI bilateral

Previous treatments/imaging/exams O No O Yes What type _____

Patient considerations (check all that apply) O Requires transportation O Allergies to contrast agents O Diabetes O Weight consideration O Claustrophobic
O Interpreter needed (language) _____ O Renal failure/dialysis O Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
O Other _____

Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed

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.	**NPI # (required for new providers)**	Date

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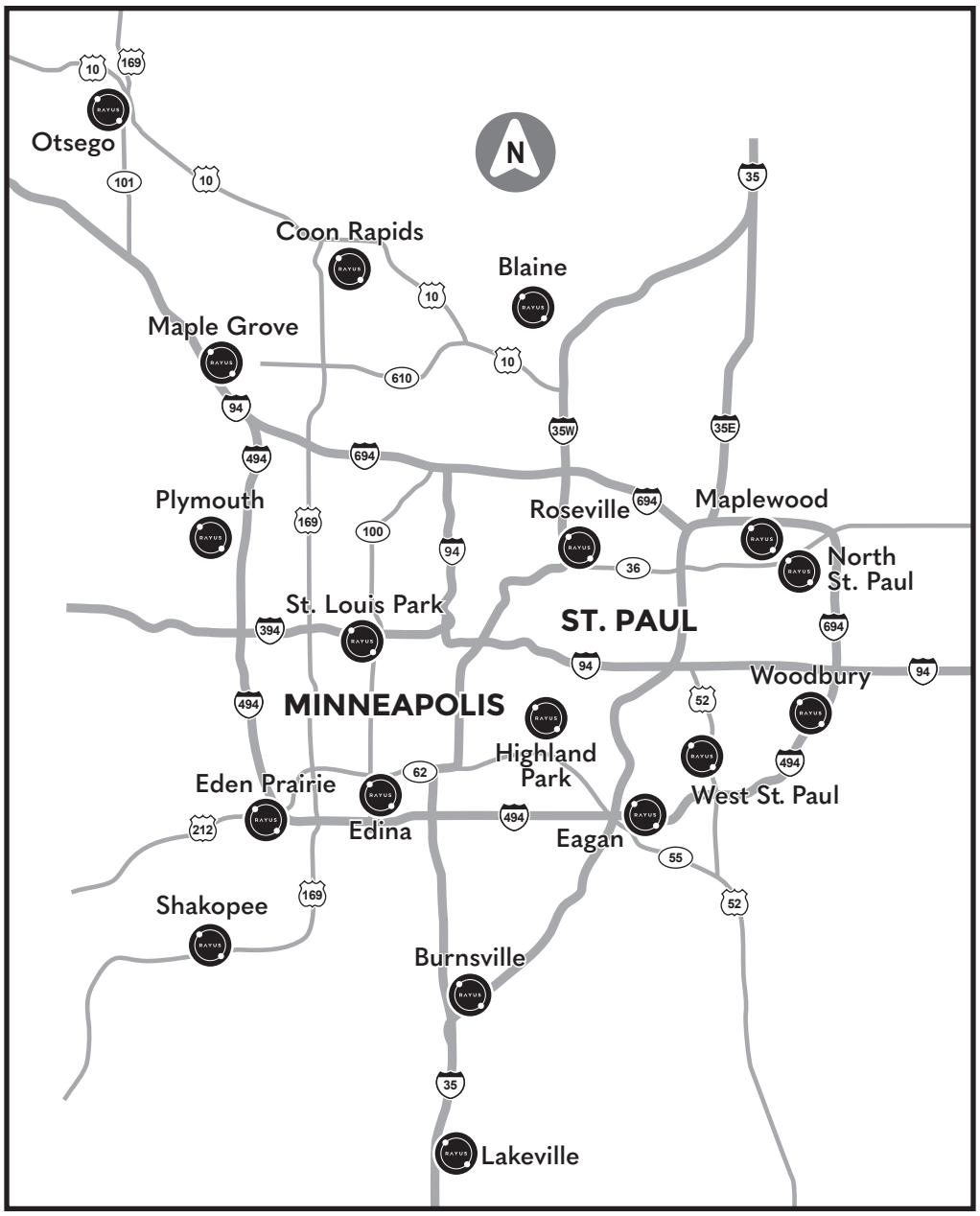

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Burnsville, MN 55337

COON RAPIDS
3833 Coon Rapids Blvd. NW, Suite 120
Coon Rapids, MN 55433

EAGAN
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Eagan, MN 55121

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Eden Prairie, MN 55344

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Edina, MN 55435

HIGHLAND PARK
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St. Paul, MN 55116

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Lakeville, MN 55044

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Maple Grove, MN 55369

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Maplewood, MN 55109

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