

**SCHEDULING**  
 Prior authorization

- DEDHAM
- HAVERHILL
- WOBURN

P: 781.329.0600      F: 781.329.1713  
 P: 978.469.0400      F: 978.469.0408  
 P: 781.932.8650      F: 781.932.8619



**If faxing an order, please include:**

- Demographics
- Insurance card
- Clinical notes
- Email BostonOrders@RAYUSradiology.com

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 #	
Patient address			
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	Date of injury	Insurance name	Insurance ID #      Authorization #

**(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

**NEURO**

- Brain and/or  Orbits
- Routine
- MS
- IAC
- Pituitary
- Seizure
- Trigeminal
- Volumetric brain imaging (NeuroQuant®)  
(Dedham, Springfield & Woburn only)  
What are you looking to measure? \_\_\_\_\_
- Spine
  - Cervical
  - Thoracic
  - Lumbar
- Neck (soft tissue)
- TMJ bilateral

**MUSCULOSKELETAL**

- Laterality:  L  R  BIL
- Foot
  - Ankle
  - Knee
  - Elbow
  - Wrist
  - Hand
  - Hip
  - Extremity \_\_\_\_\_

**BODY**

- Abdomen
  - Routine
  - MRCP w/3D recons
  - Adrenals
  - Liver
  - Pancreas
  - Kidneys
- Chest
- MR enterography (abdomen/pelvis)
- Pelvis
  - Bony
  - Organ(s)

**MRA**

- Brain
  - Circle of Willis
  - MRV of sagittal sinus
- Neck
  - Carotid arteries
  - Carotid dissection
- Abdomen
  - Abdominal aorta
  - MRV of abdomen/pelvis
  - Renal arteries
- Chest
- Extremity \_\_\_\_\_  
 L  R  BIL

**OTHER**

- Other \_\_\_\_\_

**THERAPEUTIC INJECTIONS**

(Dedham only)  
 L  R  BIL

- Shoulder
- Knee
- Hip
- Other \_\_\_\_\_

**ARTHROGRAMS**

(Dedham only)  
 L  R  BIL

- Shoulder
- Knee
- Hip
- Other \_\_\_\_\_

**X-RAY**

(Dedham only)

- Views \_\_\_\_\_
- Chest
  - Abdomen (KUB)
  - Spine
    - Cervical
    - Thoracic
    - Lumbar
  - Extremity \_\_\_\_\_  
 L  R  BIL
  - Orbits screening pre-MRI
  - Other \_\_\_\_\_

**REPORTING METHOD**     CD w/report     Portal/Web viewing     STAT: Call report # \_\_\_\_\_    Attn: \_\_\_\_\_  
 Report only     STAT: Fax report # \_\_\_\_\_    Attn: \_\_\_\_\_

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

## PATIENT PREPARATION

### MRI

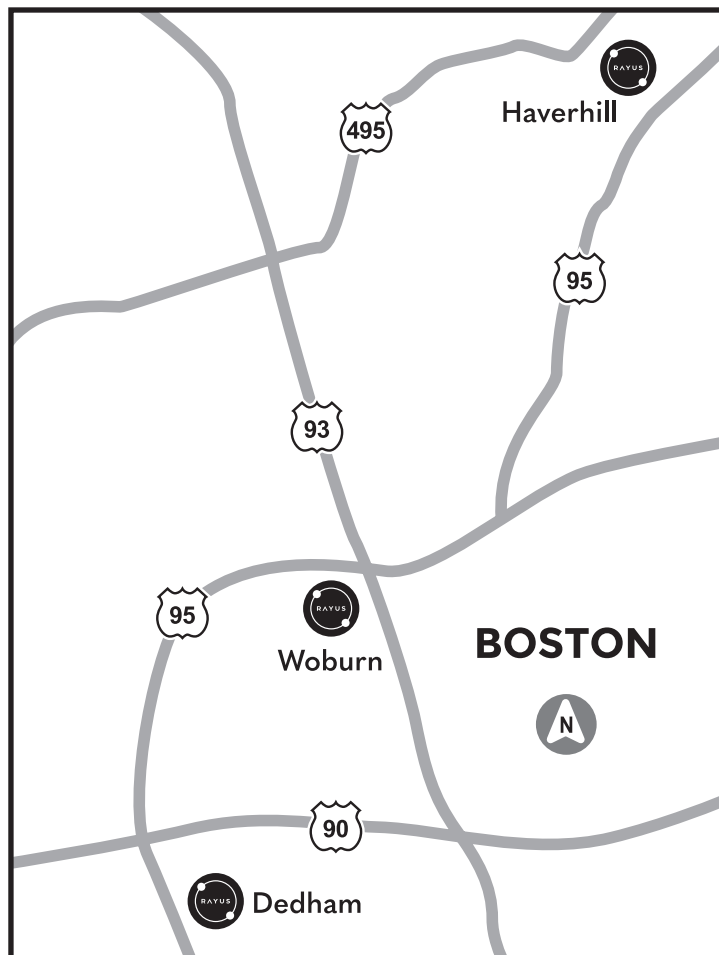
Currently, there are no known biological hazards from MRI; however, since the technique involves strong magnetic fields, certain precautions must be taken. For safety reasons, exclusion from MRI examinations includes patients with: cardiac pacemakers, cardio defibrillators (ICD), cochlear ear implants, insulin pumps, severe renal disease, internal ferromagnetic aneurysm clips in the brain, metallic shrapnel or foreign bodies in or near vital structures (e.g. eyes).

*Prior to exam, inform the office if you are/may be pregnant.*

### MRI CONTRAST STUDIES

A serum creatinine is required for patients if they:

1. Have known renal disease, including acute/chronic renal failure
2. Had a renal transplant or have a single kidney
3. Are on dialysis



CENTER	ADDRESS	MRI	OPEN MRI	THERAPEUTIC INJECTIONS	X-RAY	ARTHRO
Dedham	200 Providence Hwy., Suite 210 Dedham, MA 02026	•	•	•	•	•
Haverhill	One Park Way Haverhill, MA 01830	•				
Woburn	800 W. Cummings Park., Suite 1150 Woburn, MA 01801	•	•			