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

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

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 orbits O Brain w/ MRA
O X-ray orbits metal screening
Spine
O Cervical O Thoracic O Lumbar
O Extremity _____
O Arthrogram _____
O Other _____

CT

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

O Abdomen
O Pelvis
O Abdomen/Pelvis
O Chest
O Chest/Abdomen/Pelvis
O Lung cancer screening - use Lung Screening pad
Spine
O Cervical O Thoracic O Lumbar
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 Head
O Sinus O Maxillofacial
O Soft tissue neck
O Parathyroid
Dentascan
O Maxilla O Mandible
O Calcium score screening
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 Breast MRI
O Ultrasound

BIOPSIES/ASPIRATIONS

Body part _____
O Image-guided core biopsy - modality:
O MRI
O CT
O Ultrasound
O Fine needle aspiration
O Other_____

THERAPEUTIC PROCEDURES

O Image-guided pain 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/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

Prior studies O No O Yes Location of prior studies _____
Study read by O Tim Sellers, DC, DACBR O Edith Dal Mas, DC, 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

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RAYUS RADIOLOGY™

PATIENT PREPARATION

ARTHROGRAM • DXA SCAN • VOIDING CYSTOURETHROGRAM
No preparation is necessary.

PET/CT • NUCLEAR MEDICINE SCAN
Call the center for instructions: 503.253.1105

CT • MRI
Bring prior MRI, CT or X–ray films. Call for instructions: 503.253.1105

MAMMOGRAM
Do not wear powder, deodorant or lotion.

UPPER GI/SMALL BOWEL SERIES
- Nothing to eat or drink after 10 p.m. the evening prior to the exam.
- Refrain from chewing gum or smoking until the exam is completed.
- Note: An Upper GI with small bowel series may take several hours. Average exam time is 1½ hours.

HYSTEROSALPINGOGRAM
Call the center for instructions: 503.253.1105

BARIUM ENEMA/AIR CONTRAST

The day before the exam:
- Clear liquid only, unlimited quantity. No solid foods.
- Take 5 Dulcolax tablets at 6:30 p.m.
- At 9 p.m., take a large warm water enema (one quart or more).

The day of the exam:
- Repeat enema upon rising.

ULTRASOUND

Abdomen (Exam includes liver, pancreas, aorta, gall bladder, spleen and kidneys)
- Nothing by mouth after 10 p.m. the evening prior to the exam.
- Abdominal aorta aneurysm - No food or fluids for 6 hours.

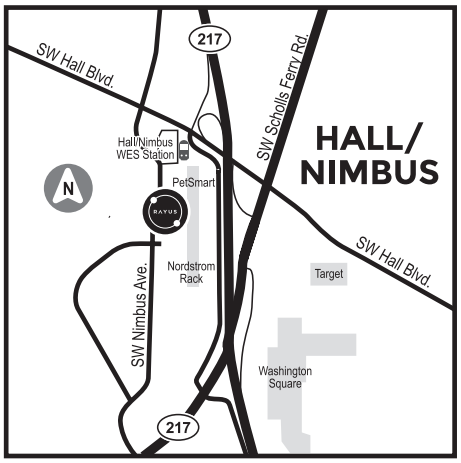
Renal
- Well hydrated.

OB/GYN (Exam includes evaluation of pregnancy, uterus, and ovaries)
- Drink 32 ounces of water one hour prior to the exam. Do not empty your bladder until the exam is completed.

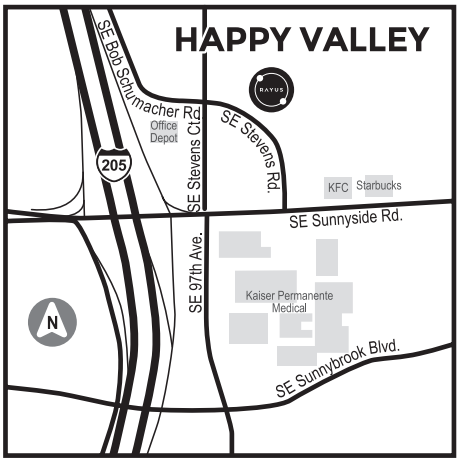
Sonohysterogram
- Drink 32 ounces of water one hour prior to your exam. Do not use the restroom until you have been directed to do so by one of our staff members.

BETHANY
1500 NW Bethany Blvd., Suite 100
Beaverton, OR 97006

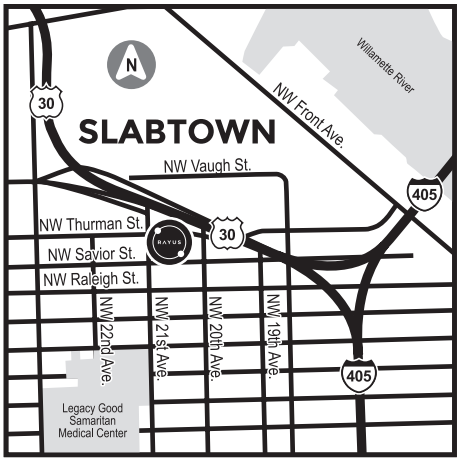
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



HALL/NIMBUS
8950 SW Nimbus Ave.
Beaverton, OR 97008



HAPPY VALLEY
10121 SE Sunnyside Rd., Suite 170
Clackamas, OR 97015



SLABTOWN
2055 NW Savier St., Suite 110
Portland, OR 97209