CHIROPRACTIC ORDER FORM

SCHEDULING
P: 503.253.1105
F: 503.535.8394
E: ORRAYUSorders@RAYUSradiology.com

○ Bethany
○ Gateway
○ Hall/Nimbus
○ Happy Valley
○ Slabtown
See back for addresses

○ Patient will call to schedule
○ Call patient to schedule

RAYUS RADIOLOGY®

Appointment date and time	Check-in 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 ○ 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? ○ No ○ Yes **If yes** ○ Initial ○ Subsequent or ○ Sequela

If you prefer, you may request: ○ **MD read only OR** ○ **Chiropractic read**

X-RAY

SPINE
- ○ Cervical spine (AP, APOM, Lat)
  - Additional views:
  - ○ Flex/Ext
  - ○ Obliques
  - ○ APOM R/L lateral bending
  - ○ AP, APOM, lat, flex, ext, obliques (Davis series)
- ○ Thoracic spine (AP, lat)
  - Additional views:
  - ○ AP, lat, swimmers
- ○ Lumbar spine (AP/PA, lat)
  - ○ AP/PA, lat
  - ○ Lat L/S spot
  - ○ Axial L/S spot
  - ○ Obliques
  - ○ Flex/Ext
  - ○ R/L lateral bending
- ○ Sacrum/Coccyx
  - ○ AP, lat
- ○ Scoliosis assessment
  - ○ AP, lat, T/L (thoracolumbar)
- ○ Other spine views (specify) _____

UPPER EXTREMITY
- ○ Shoulder ○ R ○ L
  - ○ AP with int/ext rotation
  - ○ Grashey
  - ○ Transaxial
  - ○ 'Y' view
- ○ Clavicle ○ R ○ L
- ○ Acromioclavicular joint ○ R ○ L
  - ○ With and without weight-bearing
- ○ Elbow ○ R ○ L
  - ○ AP, lat
  - ○ Radial head
- ○ Wrist ○ R ○ L
  - ○ PA, lat, obl
  - ○ Scaphoid
- ○ Hand ○ R ○ L
  - ○ PA, lat, obl

LOWER EXTREMITY
- ○ Pelvis
  - ○ AP
- ○ Hip ○ R ○ L
  - ○ AP pelvis/frog leg lateral
- ○ Knee ○ R ○ L
  - ○ AP, lat
  - ○ Tunnel
  - ○ Sunrise
  - ○ PA/Rosenberg
- ○ Ankle ○ R ○ L
  - ○ AP, lat, obl
- ○ Foot ○ R ○ L
  - ○ AP, lat, obl

CHEST/THORAX IMAGING
- ○ Chest
- ○ PA, lat ○ PA
- ○ Ribs ○ R ○ L
  - ○ Upper AP or PA, obl, PA chest
  - ○ Lower AP or PA, obl, PA chest

OSTEOPOROSIS SCREENING

DXA/BMD SCAN
- ○ Screening or ○ 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
- Including vertebral fracture assessment (*Gateway only*) ○ No ○ Yes

MRI

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

- ○ Angiogram
- ○ Arthrogram (joint injection) - Specify _____
- ○ Brain
  - ○ Imeka™ ANDI™ study

SPINE
- ○ Cervical
- ○ Thoracic
- ○ Lumbar
- ○ Upper cervical whiplash

UPPER EXTREMITY
- ○ Shoulder ○ R ○ L ○ BIL

LOWER EXTREMITY
- ○ Hip ○ R ○ L ○ BIL
- ○ Knee ○ R ○ L ○ BIL
- ○ Ankle ○ R ○ L ○ BIL
- ○ Extremity (specify) _____
- ○ Other _____

CT

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

- ○ Leg length study
- ○ Spine (specify) _____
- ○ Extremity (specify) _____
- ○ Other _____

OTHER

_____
_____
_____

Previous treatments/imaging/exams ○ No ○ Yes What type _____
Patient considerations (check all that apply) ○ Requires transportation ○ Allergies to contrast agents ○ Diabetes ○ Weight consideration ○ Claustrophobic
○ Interpreter needed (language) _____ ○ Renal failure/dialysis ○ Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
○ Other _____
Lab results Creatinine _____ BUN _____ Blood draw date _____ ○ On-site creatinine testing needed

REPORTING METHOD

○ Routine
○ Hold and call _____
○ Read and call _____
○ Patient to hand carry films/CD/report
○ STAT/ASAP
○ Next-day follow-up

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

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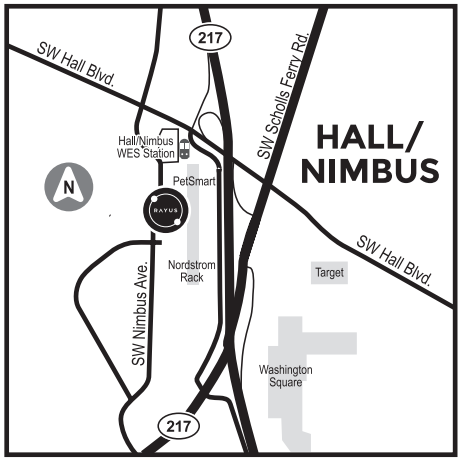
PATIENT PREPARATION

ARTHROGRAM • DXA SCAN
No preparation is necessary.

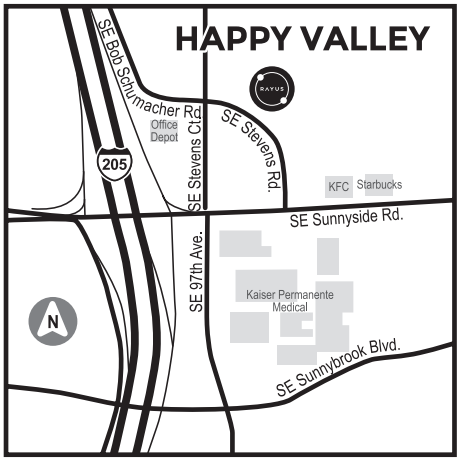
CT • MRI
Bring prior MRI, CT or X-ray films. Call for instructions: 503.253.1105

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

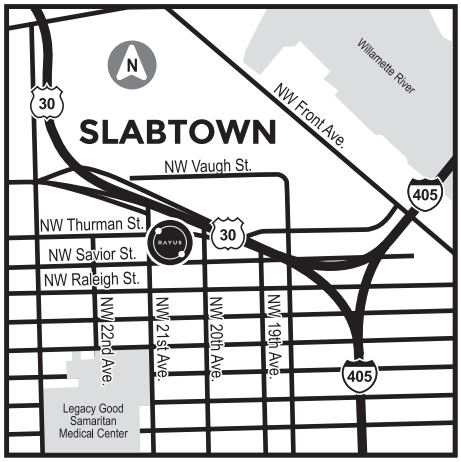
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



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