X-RAY ORDER FORM

SCHEDULING
P: 615.890.8999
F: 615.890.6053
E: TNRAYUSorders@RAYUSradiology.com

- O Patient will call to schedule
- O Call patient to schedule
- O Walk-in appointment

O CLARKSVILLE
135 Chesapeake Ln., Suite 101
Clarksville, TN 37040

O MURFREESBORO
1528 Gateway Blvd., Suite 100
Murfreesboro, TN 31729

O SMYRNA
537 Stonecrest Pkwy., Suite 102
Smyrna, TN 37167

PATIENTS
Bring this form with you to your exam.

PRE-REGISTER
myExamAnswers.com

Tax ID #81-5457003

RAYUS RADIOLOGY®

Appointment date and time	Check-in time	Patient DOB	Sex assigned at birth O M O F	O Auto O Workers' Comp O Commercial/Private
Patient name (as shown on insurance card)	Primary phone #		Secondary phone #	Date of injury
Insurance name	Insurance ID #		Group #	Pre-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.

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

X-RAY

Weight limit up to 800 lbs. ● L ● R ● BIL

Views _____

_____

_____

- O Abdomen - KUB
- O Abdomen - flat & upright w/chest
- O Ankle
- O Cervical spine
- O Complete
  - O Flex & extension
- O Chest PA/Lateral
- O Clavicle
- O Elbow
- O Eye
- O Facial bones
- O Femur
- O Finger(s) - specify _____
- O Foot
- O Forearm
- O Hand
- O Heel
- O Hip(s)
- O Humerus
- O Knee
- O Lumbar spine
- O Complete
  - O Flex & extension
  - O AP & LAT
- O Orbits
- O Pelvis
- O Ribs w/chest
- O Sacrum/Coccyx
- O Scoliosis series
- O Shoulder
- O SI joints
- O Sinus
  - O Complete
  - O Waters
- O Skull
- O Thoracic spine, 3-view
- O Tibia/Fibula
- O Wrist
- O Other _____

_____

_____

BREAST IMAGING

- O Screening mammogram

Previous treatments/imaging/exams O No O Yes What type _____
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 or 4) has only one kidney.*

REPORTING METHOD
O Fax report to _____
O Hold patient and call _____
O Call STAT to _____
O Send films/disc with patient

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