CHIROPRACTIC ORDER FORM

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

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

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

X-RAY

SPINE

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

UPPER EXTREMITY

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

LOWER EXTREMITY

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

CHEST/THORAX IMAGING

- O Chest
- O PA, lat O PA
- O Ribs O R O L
  - O Upper AP or PA, obl, PA chest
  - O Lower AP or PA, obl, PA chest

OSTEOPOROSIS SCREENING

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
- Including vertebral fracture assessment (*Gateway only*) O No O Yes

MRI

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

- O Angiogram
- O Arthrogram (joint injection) - Specify ____________________

SPINE

- O Cervical
- O Thoracic
- O Lumbar
- O Upper cervical whiplash

UPPER EXTREMITY

- O Shoulder O R O L O BIL

LOWER EXTREMITY

- O Hip O R O L O BIL
- O Knee O R O L O BIL
- O Ankle O R O L O BIL
- O Extremity (specify) ____________________
- 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 reconstructions**

- O Leg length study
- O Spine (specify) ____________________
- O Extremity (specify) ____________________
- O Other ____________________

OTHER

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____

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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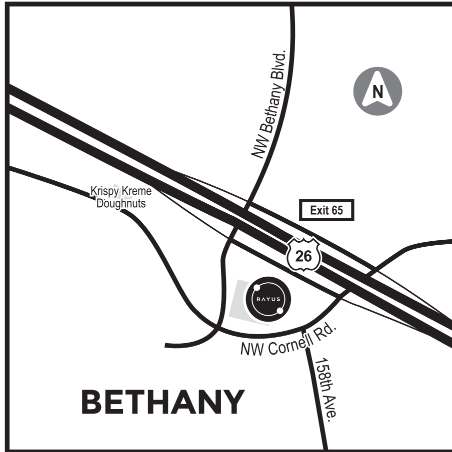
RAYUS RADIOLOGY™

PATIENT PREPARATION

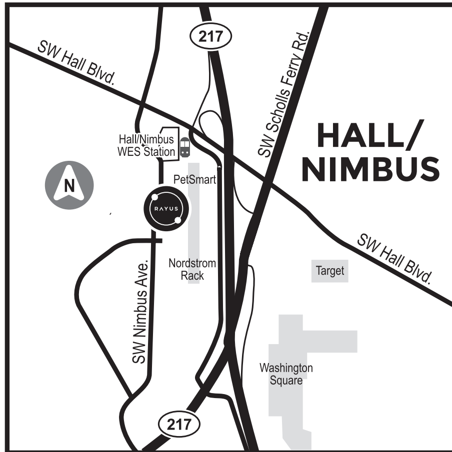
ARTHROGRAM • DXA SCAN
No preparation is necessary.

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

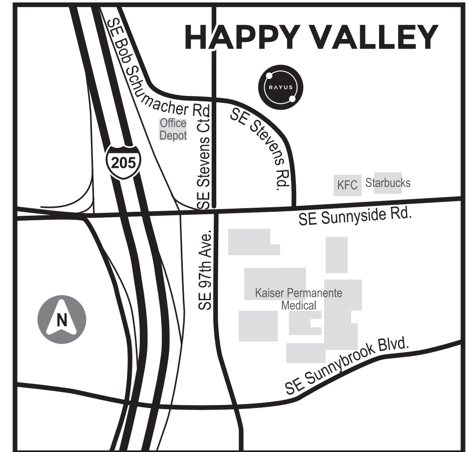


BETHANY
1500 NW Bethany Blvd.
Suite 100
Beaverton, OR 97006

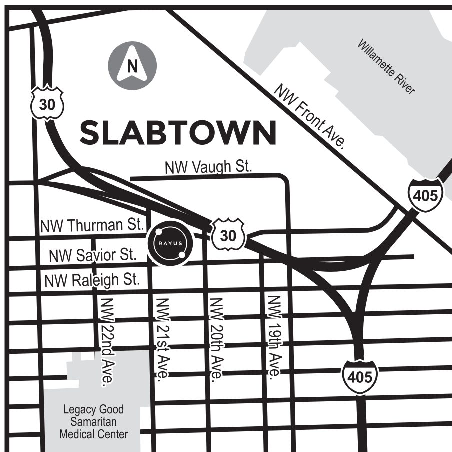
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



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