CHIROPRACTIC ORDER FORM

SCHEDULING
O Patient will call to schedule
O Call patient to schedule
Evening and weekend hours available

O ALEXANDRIA
A service of **Alomere Health**
P: 320.762.6040
F: 320.762.6038
E: alexorders@RAYUSradiology.com
RADIOLOGIST CONSULTATION
P: 320.762.6040
INSURANCE SPECIALIST
P: 320.762.6059

O SARTELL
O ST. CLOUD NORTHWEST
O ST. CLOUD SOUTH
P: 320.251.0609
F: 320.251.3806
E: RAYUSstcsched@RAYUSradiology.com
RADIOLOGIST CONSULTATION
P: 320.251.0609 press 7
INSURANCE SPECIALIST
P: 320.229.4603

RAYUS RADIOLOGY™

See back for addresses

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 #	
Referring clinic patient ID/MRN #	Authorization #/Auth. ins. phone #	Insurance ID #	

O Auto O Workers' comp O Commercial/Private | O Claustrophobic O Needs assistance | Date of injury | Attorney name/claim #

(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

Area of body | O L O R O BIL

PAIN CARE

Sartell only

O Comprehensive pain care evaluation by a physiatrist or NP

Notes _____

CT

IV contrast as clinically indicated by radiologist
O No contrast
3D reconstructions as clinically indicated by radiologist
O No 3D reconstructions

Body part _____

MRI

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

NEURO
O Brain
Spine
O Cervical
O Thoracic
O Lumbar

MSK
O Extremity (non-joint) _____
O L O R O BIL

O Joint _____
O L O R O Arthrogram (if indicated)

OTHER
O _____

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

O Therapeutic injection per radiologist discretion
(May include any of these injections - up to 3)
- Epidural steroid injection
- Facet joint injection
- Nerve block injection
- SI joint injection

O Area of injection
O Cervical
O Thoracic
O Lumbar
Levels _____

O Injection type
O Therapeutic
O Diagnostic

ULTRASOUND

O Doppler if clinically indicated by radiologist
O No Doppler
O Complete O Limited

Body part _____

BONE DENSITY

O Screening 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
- **Patient has been diagnosed with primary hyperparathyroidism**? O No O Yes

O Body composition assessment

X-RAY

Views _____

Procedure/body part _____

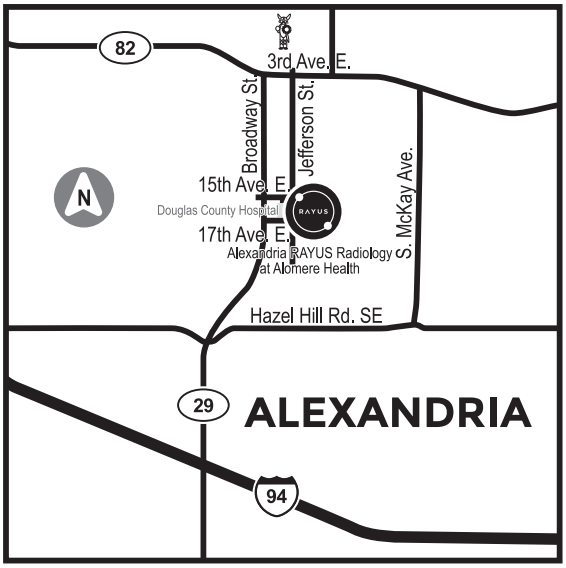
Previous treatments/imaging/exams O No O Yes If yes, what type _____
Lab results Creatinine _____ Blood draw date _____ O On-site creatinine testing needed*
**Lab values needed within 30 days of the exam for IV contrast if the patient 1) is diabetic, 2) is having chemotherapy 3) has lupus or 4) has renal impairment*

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	**Date (required)**	**Time (required)** am pm	**NPI # (required for new providers)**

ALEXANDRIA
A service of Alomere Health
111 17th Ave. E.
Alexandria, MN 56308
alexorders@RAYUSradiology.com



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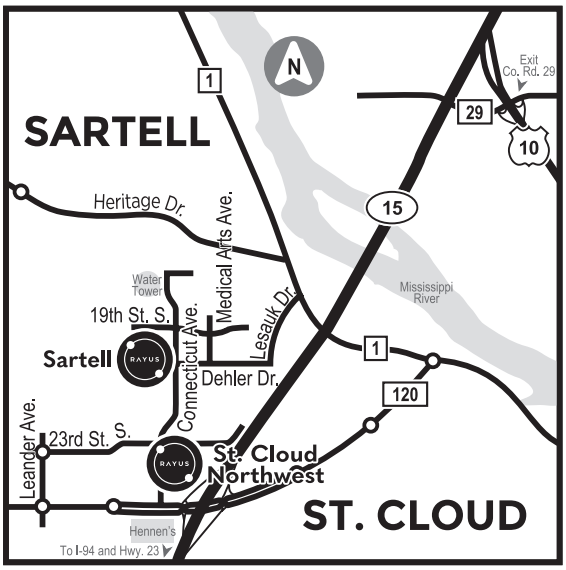

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