

SCHEDULING

- ☐ Patient will call to schedule
☐ Call patient to schedule

Evening and weekend hours available

○ 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

See back for addresses

○ SARTELL

○ ST. CLOUD NORTHWEST
○ 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



Appointment date and time		Check-in time	Patient DOB	Sex assigned at birth <input type="radio"/> M <input type="radio"/> F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #	
Referring clinic patient ID/MRN #		Authorization #/Auth. ins. phone #	Insurance ID #	
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	<input type="radio"/> Claustrophobic <input type="radio"/> 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.

Clinical Decision Support (CDS)**Required for Medicare Part B**

Modifier (determination)

G-code (vendor)

Is the exam/procedure related to an injury? ☐ No ☐ Yes **If yes** ☐ Initial ☐ Subsequent or ☐ Sequela

Area of body

☐ L ☐ R ☐ BIL

MRI

☐ IV contrast as clinically indicated by radiologist

☐ No contrast

Sedation for

☐ Pain ☐ Claustrophobia

- ☐ Arthrogram _____
☐ Angiogram _____
☐ Pre MRI orbit, X-ray (for metal) _____

CT

☐ IV contrast as clinically indicated by radiologist

☐ No contrast

○ 3D reconstructions as clinically indicated by radiologist ☐ No 3D reconstructions

☐ Sedation

- ☐ Arthrogram _____
☐ Angiogram _____

PAIN CARE

Sartell only

☐ Comprehensive pain care evaluation by pain care provider

Notes _____

PET/CT

Alexandria only

- ☐ Restaging
☐ Initial treatment
☐ Eyes to thighs
☐ Whole body
☐ Other _____

ULTRASOUND

☐ Doppler if clinically indicated by radiologist

☐ No Doppler

☐ Complete ☐ Limited

If ordering a Pelvis or OB please select one:

☐ Transvaginal study if clinically indicated by radiologist
☐ No transvaginal

X-RAY/FLUOROSCOPY

- ☐ Procedure _____
☐ Views _____

BREAST IMAGING SERVICES

- ☐ 3D screening mammogram ☐ L ☐ R ☐ BIL
☐ 3D diagnostic mammogram ☐ L ☐ R ☐ BIL
☐ 2D screening mammogram ☐ L ☐ R ☐ BIL
☐ 2D diagnostic mammogram ☐ L ☐ R ☐ BIL
☐ Ultrasound ☐ L ☐ R ☐ BIL
☐ Biopsy ☐ L ☐ R ☐ BIL
☐ Stereotactic
☐ US-guided
☐ MRI-guided
☐ MRI bilateral

BONE DENSITY

- ☐ Screening ☐ 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
 • Patient has been diagnosed with primary hyperparathyroidism?
☐ No ☐ Yes
☐ Body composition assessment

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

☐ Spine injection consultation with radiologist

☐ L ☐ R ☐ BIL

- ☐ Epidural steroid injection
☐ Nerve root block injection
☐ SI joint injection
☐ Facet joint injection
☐ Myelogram
☐ Discogram
☐ Bone marrow aspirate concentrate (BMAC)
☐ Vertebral augmentation
☐ Sympathetic block injection
☐ Kyphoplasty
☐ Arthrogram (Joint/MSK)
☐ Platelet-rich plasma (PRP)
☐ Medial branch block (MBB)
☐ Genicular knee
☐ Other _____

NUCLEAR MEDICINE

Alexandria only

- ☐ Bone scan - specify _____
☐ Whole
☐ 3-phase
☐ SPECT
☐ Limited
☐ Gastrointestinal
☐ Hepatobiliary/GB
☐ Liver or spleen
☐ Lung
☐ MUGA
☐ Renal
☐ Sentinel node
☐ Thallium/Cardiolite
☐ Thyroid
☐ Other _____

Previous treatments/imaging/exams ☐ No ☐ Yes If yes, what type _____
Lab results Creatinine _____ Blood draw date _____ ☐ 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 ☐ Routine ☐ Read and call ☐ STAT/ASAP
☐ Hold and call _____ ☐ Patient to hand carry films/CD/report ☐ Next-day follow-up

Provider name (print) _____ Provider location _____ City/Zip _____ Phone # _____

Provider signature (required) _____ Date (required) _____ Time (required) _____ am pm _____ NPI # (required for new providers) _____

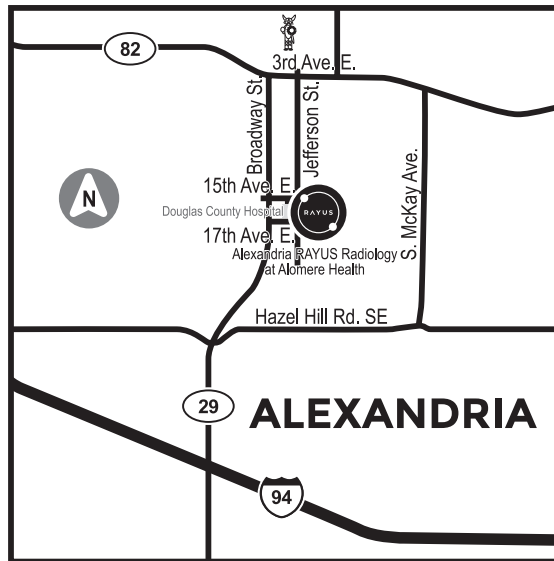
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ALEXANDRIA

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SARTELL

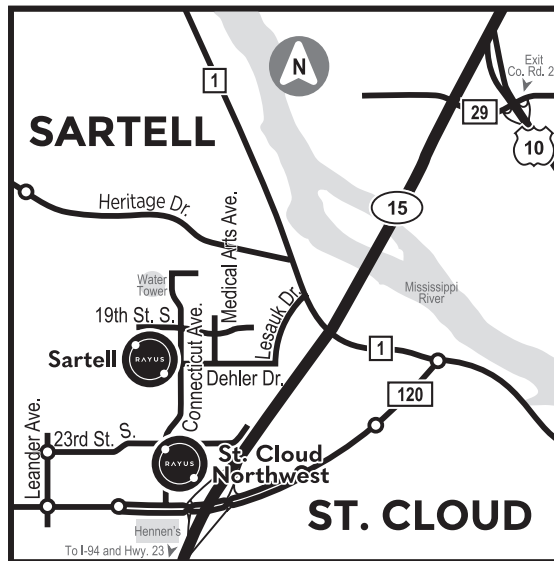
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