SCHEDULING
P: 615.890.8999
F: 615.890.6053
E: TNorders@rayusradiology.com
O Patient will call to schedule
O Call patient to schedule

O Murfreesboro
O Smyrna
See back for addresses
Tax ID #81-5457003

PATIENTS
Bring this form with you to your exam.

PRE-REGISTER
myExamAnswers.com

RAYUS RADIOLOGY™

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

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

MRI

Weight limit up to 550 lbs.

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

O L O R O BIL

NEURO
O Brain and/or O Orbits
O IACs
O Pituitary
O Neck (soft tissue)
O TMJ
O Volumetric brain imaging (NeuroQuant®)

BODY
O Abdomen
O Breast - *Murfreesboro only*
O Enterography (abdomen/pelvis) - *Murfreesboro only*
O Liver
O Kidney
O MRCP
O Pancreas
O Prostate - *Murfreesboro only*

LOWER EXTREMITY
O Ankle
O Arthrogram _____ - *Murfreesboro only*
O Foot
O Hip(s)
O Knee
O Thigh
O Pelvis–bony
O Pelvis–organ
O Tibia/Fibula

MRA (ANGIOGRAM)
O Carotid
O Circle of Willis
O Renal
O MRV brain
O Soft tissue neck

SPINE
O Cervical
O Thoracic
O Lumbar

UPPER EXTREMITY
O Arthrogram _____ - *Murfreesboro only*
O Elbow
O Finger(s)
O Forearm
O Hand
O Humerus
O Shoulder
O Wrist
O Other _____

X-RAY

Weight limit up to 800 lbs.

O L O R O 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 Other _____
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

CT

Weight limit up to 550 lbs.

If ordering a CT low-dose lung screen, use lung screening order form.

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

O Abdomen (diaphragm to iliac crest)
O Abdomen/Pelvis
O Cardiac calcium scoring - *Murfreesboro only*
O Chest
O CTA _____
O Enterography (abdomen/pelvis)
O Extremity O L O R O BIL specify _____
O Facial bones
O Head/Brain
O Kidney stone protocol (abdomen/pelvis)
O Mastoids
O Neck (soft tissue)
O Orbits
O Pelvis – bony
O Pelvis – organ
O Sinus
O Axial & coronal complete
O Coronal LTD
O Spine
O Post myelogram - *Murfreesboro only*
O Cervical
O Thoracic
O Lumbar
O Temporal bones
O TMJ
O Other _____

ULTRASOUND

Weight limit up to 600 lbs.

O Transvaginal study as clinically indicated by radiologist OR O No transvaginal

O Doppler as clinically indicated by radiologist OR O No Doppler

O L O R O BIL

O Abdomen complete
O Abdomen limited
O Aorta Duplex
O Arterial Doppler/Duplex
O Arm
O Leg w/ABI's (bilateral)
O Breast
O Carotid Doppler
O Echocardiogram Complete
O Liver
O Liver elastography
O Mesenteric Doppler
O Obstetric
O Biophysical profile (w/limited)
O OB <14 weeks + TV (if needed)
O OB 14+ weeks + TV (if needed)
O Pelvic complete
O Pelvic limited
O Pelvic & TV (if needed)
O Renal and O Bladder
O Renal w/Doppler
O Scrotal w/Doppler
O Soft tissue - specify _____
O Thyroid
O Transvaginal
O Venous
O Arm
O Leg

O Other _____

BREAST IMAGING

O Implants

O L O R O BIL

O Screening Mammogram with 3D Tomo
O Diagnostic mammogram with 3D Tomo and/or breast ultrasound as clinically indicated
O Ultrasound breast biopsy w/post mammogram (if needed)

SPECIAL PROCEDURES

(Murfreesboro only)

ULTRASOUND-GUIDED BIOPSY/ ASPIRATION
O Thyroid biopsy
O Soft tissue biopsy - specify _____
O Cyst - specify location _____

DIAGNOSTIC AND THERAPEUTIC INJECTIONS
O Pain management consult with radiologist - specify area _____
O ESI lumbar - specify level _____
O Musculoskeletal - specify joint _____
O R O L O BIL
O Arthrogram - specify joint _____
O R O L O BIL
O With steroid injection
O Facet joint injection - Lumbar - specify level _____
O Myelogram
O Cervical
O Thoracic
O Lumbar

HYSTEROSALPINGOGRAM (HSG)
O Essure confirmation
O Fertility

O DIAGNOSTIC LUMBAR PUNCTURE

BONE DENSITY

Weight limit up to 450 lbs.

(Murfreesboro only)

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

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

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P: 615.890.8999
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CDI IS NOW RAYUS RADIOLOGY™

PATIENT PREPARATION

Arrive 15 minutes before your scheduled appointment time. Notify us if you have questions or cannot keep your appointment. We will bill your insurance carrier directly. You are responsible for payment of your deductible and co-pay amounts before services are provided.

MRI

- Contact us if you have a pacemaker as they are unsafe for MRI.
- For MRCP exams – nothing to eat or drink 4 hours before the exam.
- For MRI contrast – a current (within 90 days) creatinine level* will be required for patients over the age of 60 or those with diabetes or hypertension.
- For MRI contrast – nothing to eat or drink 4 hours before exam.

CT

- For CT contrast – a current (within 90 days) creatinine level* check will be required for patients over the age of 60 or those with diabetes, hypertension or renal insufficiency.

MAMMOGRAM

- Do not wear deodorant, body powder or lotion.
- If prior mammograms are available, please obtain them prior to appointment.

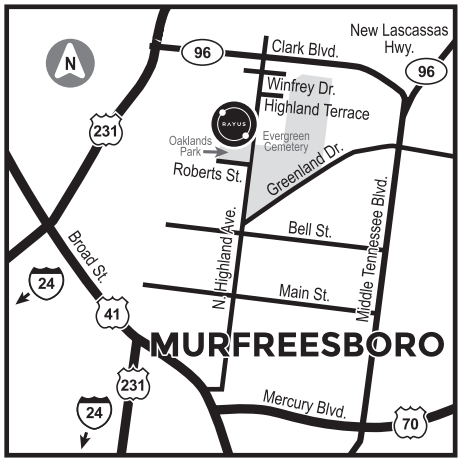
**On-site labs available for creatinine levels.*

ULTRASOUND

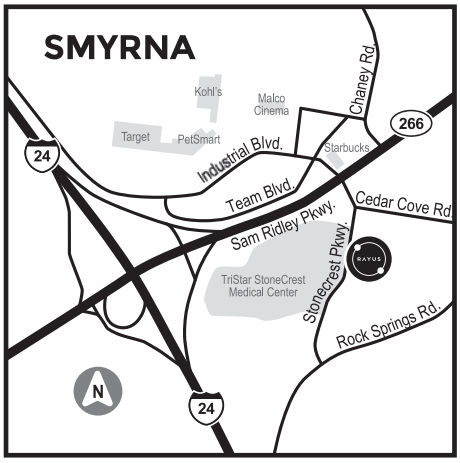
- Abdomen, gallbladder and renal doppler – nothing to eat or drink 8 hours before the exam.
- OB < 15 weeks – drink 24-32 oz. of water at least 1½ hours before exam. Transvaginal, if needed.
- OB > 16 weeks – no prep.
- Renal – drink 16 oz. of water one hour prior to exam.
- Pelvic – drink 24-32 oz. of water at least 1½ hours before exam. Come with a full bladder.

X-RAY

- Hysterosalpingogram – for intrauterine birth control devices, include placement date. Exams must be scheduled 3 months post placement.



MURFREESBORO
1001 N. Highland Ave.
Murfreesboro, TN 37130



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