VASCULAR AND INTERVENTIONAL RADIOLOGY CLINICAL SERVICES ORDER FORM

CDI IS NOW RAYUS RADIOLOGY™

SCHEDULING
P: 214.420.5400
F: 214.420.5401
E: TXimagingorders@RAYUSradiology.com
Tax ID #46-5265469
NPI #1164829214

DESOTO
1750 N. Hampton Rd.
DeSoto, TX 75115

O Patient will call to schedule
O Call patient to schedule

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	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.

Clinical Decision Support (CDS)
Required for Medicare Part B (MRI only)

Modifier (determination)	G-code (vendor)

● R ● L ● BIL

CONSULTATION

- O Kyphoplasty/Vertebroplasty*
- O Leg swelling
- O Non-healing lower extremity ulcer
- O Pelvic venous congestion
- O Peripheral artery disease or critical limb ischemia*
- O Uterine fibroids
- O Varicocele*
- O Varicose veins
- O Venous disease*
- O Other _____

VASCULAR PROCEDURES

- O Arterial angiograms*
- O A/V shuntogram/Venous angioplasty/Declot
- O Mediport
- O Permacath
- O Tunneled PICC
- O Quinton catheter
- O Venogram

VASCULAR DIAGNOSTIC TESTING

- O ABI
  - O With exercise
  - O Without exercise
- O Venous ultrasound incompetence study
- O Arterial ultrasound
- O Per provider with consult

BIOPSY

- O Bone marrow
- O Liver percutaneous
- O Liver transjugular
  - O HPVG – wedge and free hepatic pressures
- O Lung percutaneous
- O Thyroid/Neck
- O Other _____

**Requires consult with an Interventional Radiologist before proceeding - all appropriate imaging will be ordered by the Interventional Radiologist.*

INTERVENTIONAL RADIOLOGY PROCEDURES

- O Abscess tube
- O Gastrostomy tube
- O Paracentesis/Thoracentesis
- O Arthrocentesis
  - O Hip
  - O Knee
  - O Wrist
  - O Other _____
- O Blood patch
- O Epidural steroid injection
  - O Cervical
  - O Lumbar
  - O Thoracic
- O Facet joint injection
  - O Lumbar
  - O Thoracic
  - O Other _____
- O IVC filter
  - O Placement
  - O Removal
- O Lumbar puncture
- O Radiofrequency (RF) rhizotomy*
- O Sacroiliac (SI) joint injection
- O Therapeutic joint injection
  - O Hip
  - O Knee
  - O Shoulder
  - O Other _____
- O Trochanteric bursa injection
- O Uterine fibroid embolization*
  - O Consult
- O EndoAFV (WavelinQ)
- O Other _____

NOTES/HISTORY/LABS

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