PODIATRY SPECIALIST ORDER FORM

SCHEDULING
See specific market

O Patient will call to schedule
O Call patient to schedule

GENEVA
1416 S. Randall Rd., Suite 180
Geneva, IL 60134
P: 630.208.9325
F: 630.208.9326
E: ILorders@RAYUSradiology.com

RAYUS RADIOLOGY™

OFFICIAL MEDICAL PROVIDER
US SKI & SNOWBOARD OFFICIAL MEDICAL PROVIDER · USA BOBSLED+ SKELETON PARTNER · USSPEEDSKATING

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 Government O L&I/Workers' comp O Commercial/Private O Auto O No insurance	Date of injury		

(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

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

MRI

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

O Achilles	O L	O R	O BIL
O Ankle/Hindfoot*	O L	O R	O BIL
O Foot/Midfoot**	O L	O R	O BIL
O Toe/Forefoot	O L	O R	O BIL
O Other _____	O L	O R	O BIL

**Includes the insertions of the posterior tibial tendon and the peroneal tendons*
***Midfoot includes the cuneiforms, metatarsals and the Lisfranc ligament*

CT

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

O 3D reconstructions as clinically indicated by radiologist OR O No 3D reconstructions

O Ankle/Hindfoot	O L	O R	O BIL
O Foot/Midfoot	O L	O R	O BIL
O Toe/Forefoot	O L	O R	O BIL
O Other _____	O L	O R	O BIL

X-RAY

O Area of body _____
O L O R O BIL

Views _____

ULTRASOUND

O Area of body _____
O L O R O BIL

NOTES/HISTORY

_____

_____

_____

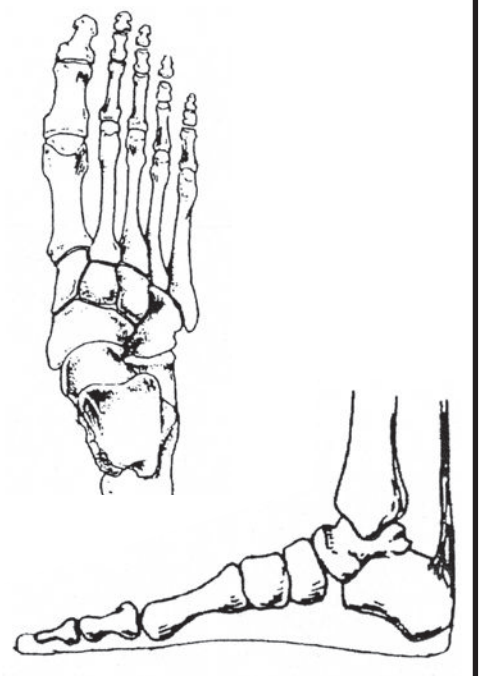
_____

_____

_____

_____

CIRCLE AREA OF INTEREST



Patient pain (check all that apply) O Acute O Chronic O Right O Left O Bilateral O Anterior O Posterior Duration _____
Previous treatments/imaging/exams O No O Yes What type _____
Patient considerations (check all that apply) O Special assistance required O Allergies to contrast agents O Diabetes O Weight consideration O Claustrophobic
O Interpreter needed (language) _____ O Renal failure/dialysis O Other _____
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed*
**Lab values may be needed within 6 weeks 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 history of kidney or liver disease*

REPORTING METHOD O Routine O STAT/ASAP O Next-day follow-up O RAYUS web portal O Report only O Patient to hand carry O Read and call _____ O Fax report to _____

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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