SCHEDULING
P: 800.537.0005
F: 317.846.0557
E: INDYsched@RAYUSradiology.com

O Patient will call to schedule
O Call patient to schedule

Fax completed order form and copy of both sides of insurance card.

O Non-ambulatory
O Needs assistance

O Avon
O Bloomington
O Carmel
O Fishers
O Greenwood
O Indianapolis E.
O Indianapolis NW
O Lafayette
O Muncie
O Noblesville
O Terre Haute

See back for addresses

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	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.

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)

1. Metal in body or eye(s)	O Y O N
2. Pacemaker	O Y O N
3. Defibrillator	O Y O N
4. Aneurysm clip(s)	O Y O N
5. Pain pump	O Y O N
6. Neurostimulator(s)	O Y O N
7. Breast tissue expander(s)	O Y O N
8. Implant(s)	O Y O N
9. Pregnant	O Y O N
10. Diabetic, history of cancer or kidney disease	O Y O N
11. 60-years or older	O Y O N

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast
O Sedation for: O Pain O Claustrophobia
O 3T MRI *(Carmel and Greenwood only)*
O L O R O BIL
O Arthrogram/MR to follow area of body
O Other _____

NEURO
O Brain and/or O Orbits
O IACs
O Pituitary
O TMJ
O Neck (soft tissue)

SPINE
O Cervical
O Thoracic
O Lumbar

BODY
O Chest
O Abdomen
O MRCP w/3D
O Prostate w/DynaCAD
O Sacrum/Coccyx
O Pelvis
O Hip(s)

UPPER EXTREMITY
O Shoulder
O Elbow
O Wrist
O Hand

LOWER EXTREMITY
O Thigh
O Knee
O Tibia/Fibula
O Ankle (arch to hind foot)
O Foot (arch to toes)

MRA
O Brain
O Neck/Carotids
O Renal arteries

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 L O R O BIL
O Arthrogram/CT to follow area of body
O Other _____

CTA
O Abdomen (aorta)
O Body part _____

NEURO
O Head and/or O Orbits
O Facial bones
O Temporal bones
O Sinus
O Full O Limited
O TMJ
O Neck (soft tissue)

SPINE
O Cervical
O Thoracic
O Lumbar

BODY
O Chest
O Abdomen
O KUB abdomen/pelvis (stone protocol)
O Pelvis
O Hip(s)
O Urogram abdomen/pelvis

UPPER EXTREMITY
O Shoulder
O Elbow
O Wrist

LOWER EXTREMITY
O Knee
O Ankle

ULTRASOUND

(Avon, Carmel, Greenwood, Indianapolis NW and Muncie only)
O Transvaginal study if clinically indicated by radiologist OR O No transvaginal
O Abdominal/Pelvis Doppler if clinically indicated by radiologist OR O No Doppler
O L O R O BIL
O Soft tissue neck
O Carotid/Vertebral artery
O Abdomen
O Limited O Complete
O Renal and O Bladder
O OB < 14 weeks
O OB > 14 weeks
O Pelvis O Complete O Limited
O Scrotum O Doppler
O Arterial Doppler of upper/lower extremities
O Venous Doppler of upper/lower extremities
O Soft tissue mass
O Other _____

NUCLEAR MEDICINE

(Carmel and Muncie only)
O SPECT as clinically indicated by radiologist OR O No SPECT
O Bone - Whole/Limited/3-Phase: specify _____
O White blood cell
O Cisternogram
O Gastric emptying
O ProstaScint
O Renal
O DaTscan
O Thyroid
O MUGA
O Hepatobiliary/Gallbladder
O Other _____

CT-GUIDED THERAPEUTIC INJECTIONS

O L O R O BIL
O Marcaine & Steroid O Marcaine only
O Shoulder
O Hip
O Knee
O Other _____

KYPHOPLASTY

O Evaluate - Office consultation and possible treatment as determined by the radiologist

If you would like to order a mammogram or bone density screening, please use our breast and body order form.

DIAGNOSTIC INJECTIONS/ PAIN MANAGEMENT PROCEDURES

(Avon, Carmel, Fishers, Greenwood and Noblesville only)
O Office consultation and possible treatment as determined by radiologist
O Bone marrow aspirate concentrate (BMAC) (*Carmel only*)
O Platelet rich plasma (PRP) *(Carmel only)*
O Myelogram/CT to follow
O Cervical *(Carmel only)* O Thoracic *(Carmel only)* O Lumbar
O Discogram/CT to follow
O Cervical O Thoracic O Lumbar
O Epidural steroid injection
O Cervical O Thoracic O Lumbar
O Selective nerve root block
Levels _____
O Facet joint injection
Levels _____
O Joint injection - specify _____
O Marcaine & Steroid O Marcaine only
O Other _____

X-RAY

(Avon, Carmel, Fishers, Greenwood, Indianapolis E., Indianapolis NW, Lafayette and Muncie only)
O L O R O BIL
Area of body _____
Views _____

O On-site creatinine testing needed? Creatinine _____ Blood draw date _____

REPORTING METHOD O STAT/ASAP O STAT call _____ O CD to provider's office

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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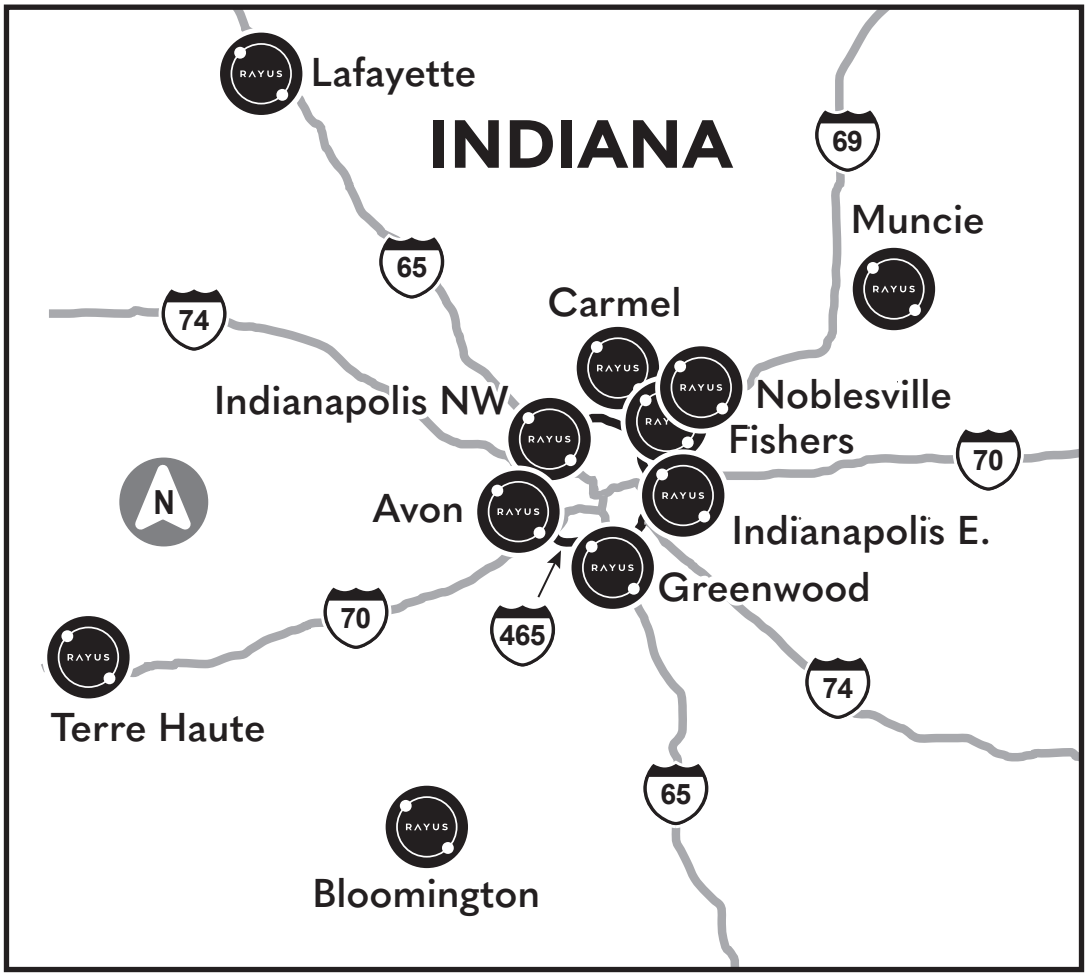

CENTER	ADDRESS	3T MRI	HIGH-FIELD MRI	HIGH-FIELD OPEN MRI	CT	INJECTIONS FOR PAIN	NUCLEAR MEDICINE	BONE DENSITY	3D MAMMO	ULTRA-SOUND	X-RAY
Avon	8607 E. US Hwy. 36, Suite 200 Avon, IN 46123		●		●	●		●	●	●	●
Bloomington	3802 Industrial Blvd., Suite 4 Bloomington, IN 47403		●	●	●						
Carmel	11900 N. Pennsylvania St., Suite 100 Carmel, IN 46032	●	●		●	●	●	●		●	●
Fishers	10206 Lantern Rd. Fishers, IN 46037		●		●	●					●
Greenwood	521 E. County Line Rd., Suite D Greenwood, IN 46143	●	●		●	●		●		●	●
Indianapolis E.	1250 N. Post Rd., Suite A Indianapolis, IN 46219		●		●						●
Indianapolis NW	7151 Marsh Rd., Suite 100 Indianapolis, IN 46278		●		●			●	●	●	●
Lafayette	3738 Landmark Dr., Suite D Lafayette, IN 47905		●	●	●						●
Muncie	3631 N. Morrison Rd., Suite 105 Muncie, IN 47304		●		●			●	●	●	●
Noblesville	13436 Tegler Dr., Suite 400 Noblesville, IN 46060		●	●	●	●					
Terre Haute	4313 S. 7th St. Terre Haute, IN 47802		●	●	●						