Important: Government-funded imaging scans require written orders.

SCHEDULING
P: 952.541.1840
F: 952.543.6524
E: TCorders@RAYUSradiology.com

O Patient will call to schedule
O Call patient to schedule

INSURANCE SPECIALIST LINE
P: 952.541.1111

RADIOLOGIST CONSULTATION HOTLINE
P: 888.541.SCAN (7226)

O Blaine
O Burnsville
O Coon Rapids
O Eagan
O Eden Prairie
O Highland Park
O Lakeville
O Maple Grove
O Maplewood
O North St. Paul
O Otsego
O Plymouth
O Roseville
O Shakopee
O St. Louis Park
O West St. Paul
O Woodbury
See back for addresses

RAYUS RADIOLOGY™

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 #	Group #	
O Auto O Workers' comp O Commercial/Private — 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.

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)

(REQUIRED) Area of body O Cervical O Thoracic O Lumbar O R O L O BIL

MRI

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

O MRI
- O High-field MRI
- O 3T MRI
- O Open MRI
- O Angiogram
- O Arthrogram (joint injection)
- O Brain volumetric imaging

O OPEN UPRIGHT MRI
- O Flexion
- O Extension
- O Standing
- O Other _____

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

X-RAY

Views _____

_____

_____

_____

PET/CT

Indicate (re: cancer)
O History of, or O Current
O Initial treatment
O Subsequent treatment

DIAGNOSTIC AND THERAPEUTIC INJECTIONS

Arthrogram (joint/MSK):
O Diagnostic O Therapeutic
- O Bone marrow aspirate concentrate (BMAC)
- O Consultation for regenerative medicine (BMAC/PRP)
- O Discogram
- O Epidural steroid injection
- O Facet joint
- O Facet nerve
- O Nerve root block
- O Nucleoplasty
- O MBB (Medial Branch Block)
- O Myelogram
- O Platelet rich plasma (PRP)
- O Rhizotomy (RF)
- O SI Joint
- O Spine Injection consultation with radiologist
- O Sympathetic block
- O Transforaminal epidural
- O Vertebral augmentation/Kyphoplasty
- O Vertebroplasty
- O Other _____

BONE DENSITY

O Screening 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

O Body composition assessment

QCT

O QCT
Height _____ Weight _____

ULTRASOUND

O Doppler if clinically indicated by radiologist OR O No Doppler

If ordering a Pelvis or OB please select one:

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

NUCLEAR MEDICINE

- O Brain/Brain SPECT
- O Hepatobilary/GB
- O Gallium whole body
- O Liver or spleen
- O Gastrointestinal
- O Lymphangiogram
- O Bone scan _____
- O Other _____

INTERVENTIONAL CONSULTATIONS AND PROCEDURES

O RAYUS Vascular consultation to evaluate for:
- O PAD/CLI
- O Non-healing wound
- O Varicose veins
- O Pelvic congestion
- O Uterine fibroid embolization

O Other _____

BREAST IMAGING SERVICES

- O 3D tomosynthesis mammogram
  - O Screening O Diagnostic
  - O Proceed with diagnostic workup per radiologist's discretion (Medicare requires new orders for US, MR, Bx/asp)
- O Ultrasound
- O Biopsy
  - O Stereotactic O US-guided O MRI-guided
- O MRI bilateral

Previous treatments/imaging/exams O No O Yes What type _____

Patient considerations (check all that apply) O Requires transportation O Allergies to contrast agents O Diabetes O Weight consideration O Claustrophobic
O Interpreter needed (language) _____ O Renal failure/dialysis O Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
O Other _____

Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed

REPORTING METHOD
O Routine
O Hold and call _____
O Read and call _____
O Patient to hand carry films/CD/report
O STAT/ASAP
O Next-day follow-up

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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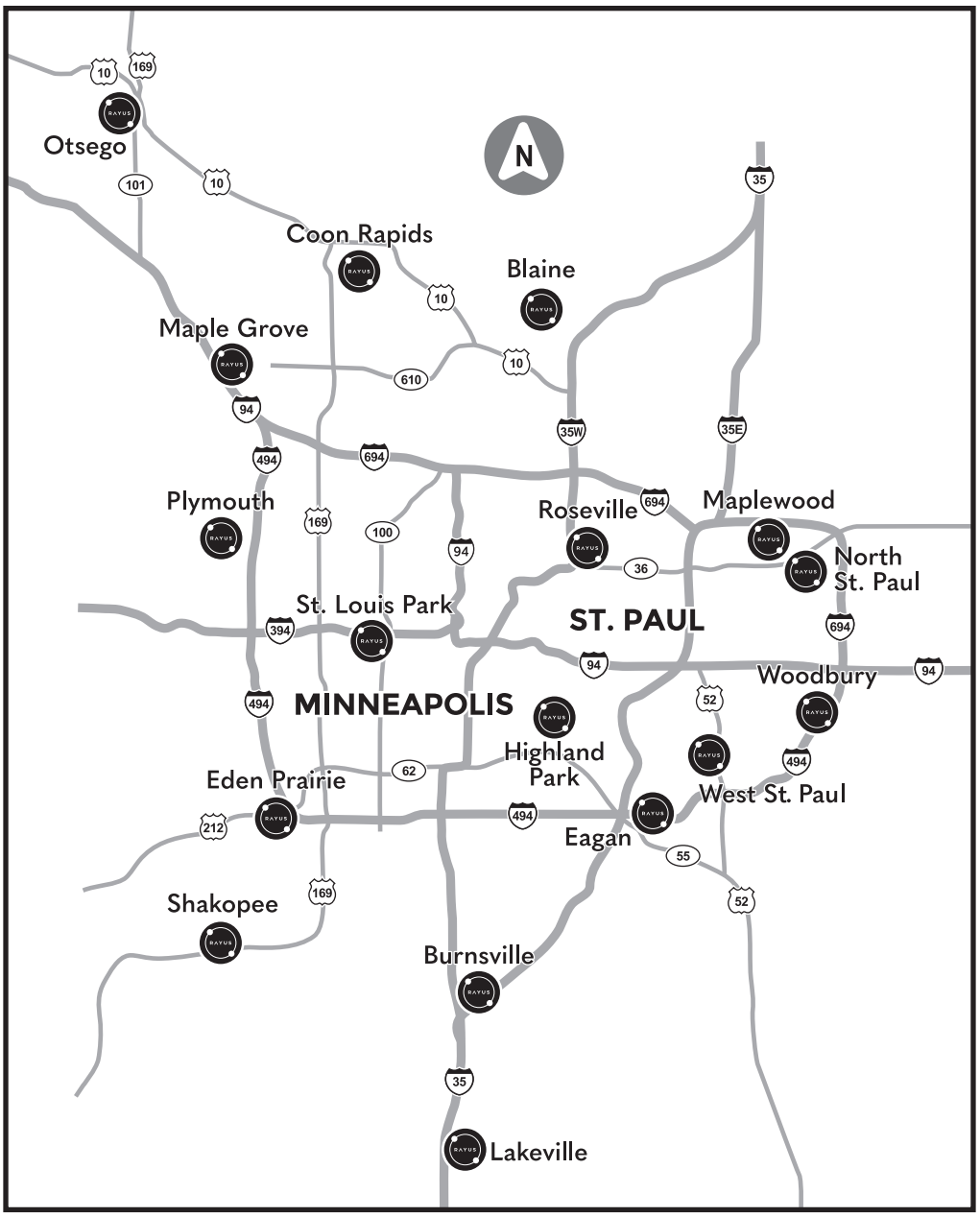

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Blaine, MN 55449

BURNSVILLE
675 E. Nicollet Blvd., Suite 150
Burnsville, MN 55337

COON RAPIDS
3833 Coon Rapids Blvd. NW, Suite 120
Coon Rapids, MN 55433

EAGAN
2700 Vikings Cir., Suite 110
Eagan, MN 55121

EDEN PRAIRIE
775 Prairie Center Dr., Suite 260
Eden Prairie, MN 55344

HIGHLAND PARK
2270 Ford Pkwy., Suite 202
St. Paul, MN 55116

LAKEVILLE
10438 185th St. W., Suite 100
Lakeville, MN 55044

MAPLE GROVE
9630 Grove Cir. N., Suite 100
Maple Grove, MN 55369

MAPLEWOOD
1790 Beam Ave.
Maplewood, MN 55109

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5775 Wayzata Blvd., Suite 190
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232 Wentworth Ave. E.
West St. Paul, MN 55118

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6025 Lake Rd., Suite 130
Woodbury, MN 55125