SCHEDULING
O Patient will call to schedule
O Call patient to schedule

O DESOTO
O MANSFIELD
P: 214.420.5400

O MCKINNEY
O PLANO
O RICHARDSON
P: 972.920.0120

E: TXimagingorders@RAYUSradiology.com
See back for fax numbers and 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	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)

O R O L O BIL

MRI

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

O Arthrogram _____
O Other _____

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

SPINE
O Cervical
O Thoracic
O Lumbar

BODY
O Chest
O Abdomen
O Liver
O Liver elastography
O Enterography (abd/pel)
O MRCP
O Pelvis
O Hip(s)
O Breast bilateral
O Prostate

UPPER EXTREMITY
O Shoulder
O Elbow
O Wrist
O Hand

LOWER EXTREMITY
O Femur
O Knee
O Tibia/Fibula
O Ankle
O Foot

MRA
O Head
O Carotid
O Aorta w/runoff
O Renal

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 Arthrogram _____
O Heart calcium scoring
O Other _____

NEURO
O Head
O IAC/Temporal bones
O Facial bones
O Pituitary
O TMJ
O Neck (soft tissue)
O Sinus
O Complete O Limited

SPINE
O Cervical
O Thoracic
O Lumbar

BODY
O Chest
O Lung screening
O Abdomen
O Abdomen/Pelvis
O Enterography (abd/pel)
O Pelvis
O Hip(s)

UPPER EXTREMITY
O Shoulder
O Elbow
O Wrist
O Hand

LOWER EXTREMITY
O Knee
O Ankle
O Foot

CTA
O Brain
O Aorta
O Chest
O Abdomen
O Pelvis
O Lung (PE)
O Carotid
O Mesenteric
O Renal

X-RAY

Views _____

O Skeletal survey
O Spine
O Cervical
O Thoracic
O Lumbar
O Scoliosis series
O Chest
O Rib series
O Pelvis
O Hip(s)
O Other _____
O Abdomen/KUB
O Shoulder
O Humerus
O Elbow
O Forearm
O Wrist
O Hand
O Knee
O Ankle
O Foot

SPECIAL PROCEDURES

O Breast biopsy
O EndoAFV (WavelinQ)
O Hip arthrocentesis
O Myelogram
O Cervical
O Thoracic
O Lumbar
O Thyroid biopsy (*DeSoto only*)
O Other _____

ULTRASOUND

O Doppler if clinically indicated by radiologist
OR O No Doppler

O Transvaginal if clinically indicated by radiologist
OR O No transvaginal

O Abdomen complete (diaphragm to iliac crest)
O Aorta
O Breast
O Carotid artery
O Gallbladder
O Liver
O Liver Doppler
O Liver w/elastography
O Obstetric
O 1st trimester
O 2nd trimester
O 3rd trimester
O Pelvis (Iliac crest to pubic symphysis)
O Renal and O Bladder
O Scrotum O Doppler
O Soft tissue
O Transvaginal
O Thyroid/Parathyroid
O Arterial Doppler
O Upper extremity
O Lower extremity
O Venous Doppler
O Upper extremity
O Lower extremity
O Other _____

BONE DENSITY

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

MAMMOGRAPHY 3D

O Screening or O Diagnostic
O Screening mammogram, and if indicated, an additional diagnostic mammogram and/or breast ultrasound

INTERVENTIONAL PROCEDURES

(DeSoto only)

O Biopsy
O Liver
O Lung
O Thyroid
O Declot/Fistulagram
O Kyphoplasty/Vertebroplasty
O Permacath
O Check
O Exchange
O Placement
O Removal
O Other _____
O Vascular consult and treat:
O Peripheral artery disease/ Critical limb ischemia
O Varicose veins
O Uterine fibroid embolization
O Non-healing wound
O Pelvic congestion
O Varicocele
O Lower extremity swelling

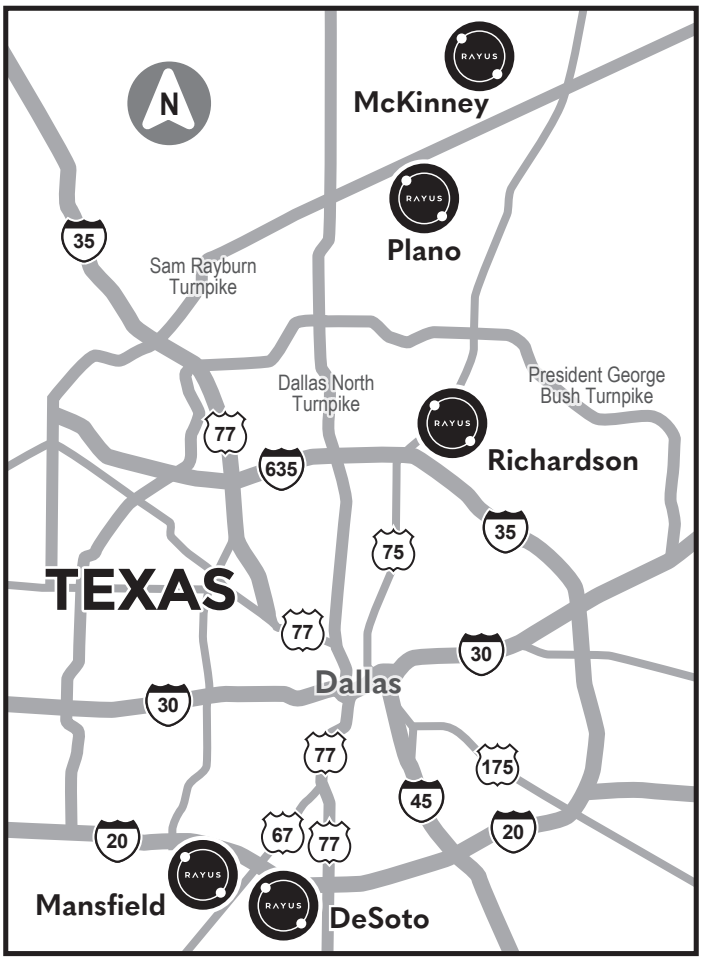
Patient considerations (check all that apply) O Claustrophobic O Sedation (administered by RAYUS Radiology) *All patients receiving sedation require a driver.*
Lab results Creatinine _____ BUN _____ Blood draw date _____ O On-site creatinine testing needed

REPORTING METHOD
O STAT call # _____ O STAT fax # _____ O STAT/ASAP
O CD to provider's office O Patient to hand carry CD/report

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

For easy and convenient access to your patients report, ask us about access to our Medical Professional Portal.

RAYUS RADIOLOGY™



CENTER	PHONE/FAX	ADDRESS	HIGH-FIELD MRI	CT	ULTRA-SOUND	MAMMO	DXA	X-RAY	OTHER SERVICES
DeSoto	P: 214.420.5400 F: 214.420.5401	1750 N. Hampton Rd. DeSoto, TX 75115	●	●	●	●	●	●	3D mammography, Bone density, Breast cancer risk assessment, Breast MRI, Interventional radiology procedures, Biopsies, Kyphoplasty, Arthrogram, Myelogram
Mansfield	P: 214.420.5400 F: 817.453.8082	2975 E. Broad St., Suite 101 Mansfield, TX 76063	● (Open)	●	●			●	Arthrogram, Breast MRI
McKinney	P: 972.920.0120 F: 214.592.0035	7300 Eldorado Pkwy., Suite 170 McKinney, TX 75070	● (Oval)	●	●	●	●	●	3D mammography, Breast caner risk assessment, Breast MRI, Bone density
Plano	P: 972.920.0120 F: 972.208.1421	8080 Independence Pkwy., Suite 105 Plano, TX 75025	● (Wide-bore)	●	●	●	●	●	3D mammography, Breast cancer risk assessment, Breast biopsies, Arthrogram, Bone density
Richardson	P: 972.920.0120 F: 972.238.1222	4140 E. Renner Rd., Suite 100 Richardson, TX 75082	● (Open)	●	●			●	Arthrogram