

SCHEDULING
P: 920.996.0724
F: 920.996.0728

☐ Appleton
See back for address

☐ Patient will call to schedule
☐ Call patient to schedule

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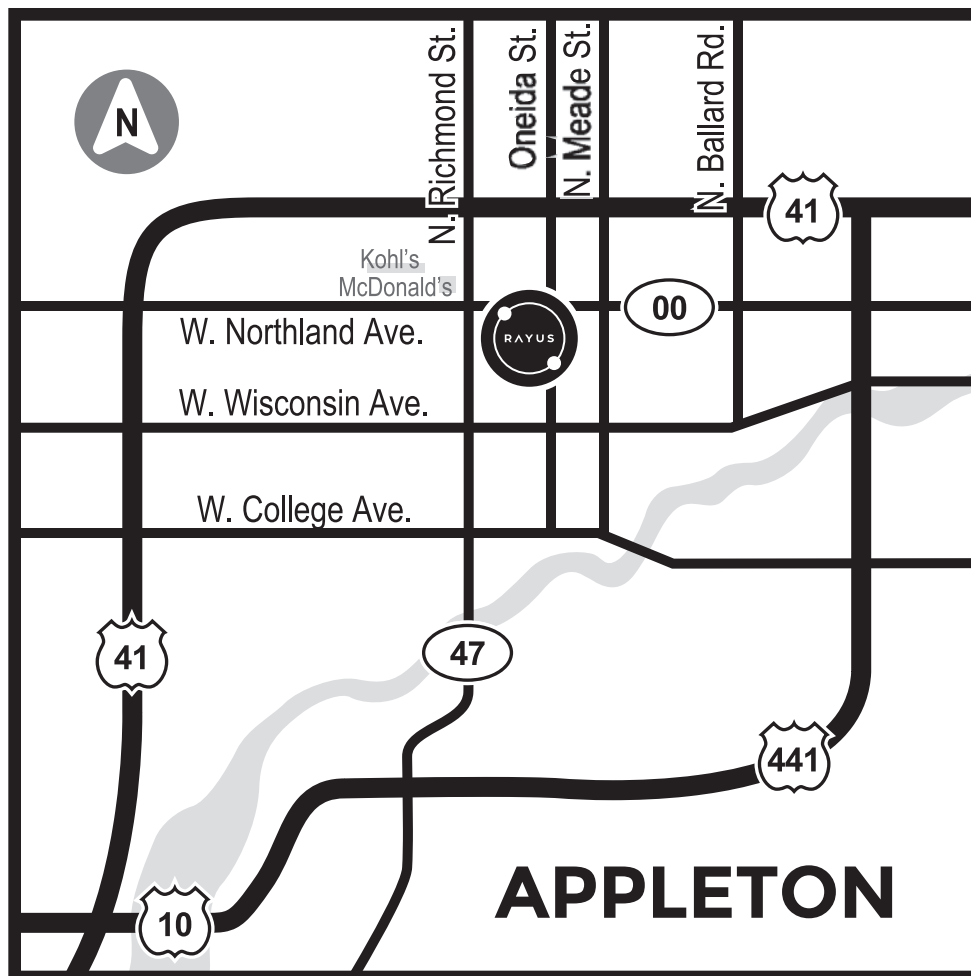


Appointment date and time	Check-in time	Patient DOB	Sex assigned at birth <input type="radio"/> M <input type="radio"/> F	Weight
Patient name (as shown on insurance card)	Primary phone #		Secondary phone #	
Address	City		State	Zip
Bring complete insurance information to appointment				
Insurance name	Insurance ID #		Group #	
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	Date of injury	Pre-authorization/Pre-certification #		
(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		
		Modifier (determination)	G-code (vendor)	
Is the exam/procedure related to an injury? <input type="radio"/> No <input type="radio"/> Yes If yes <input type="radio"/> Initial <input type="radio"/> Subsequent or <input type="radio"/> Sequela				

MRI		
<input type="radio"/> Without contrast <input type="radio"/> With and without contrast <input type="radio"/> Contrast as clinically indicated based on imaging protocol		
Area to be scanned _____		
Patient pain (check all that apply) <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral <input type="radio"/> Anterior <input type="radio"/> Posterior Duration _____		
Previous MRI? <input type="radio"/> No <input type="radio"/> Yes Where _____		
Previous surgery on area to be scanned? <input type="radio"/> No <input type="radio"/> Yes		
If lumbar spine, would you like weight-bearing? <input type="radio"/> No <input type="radio"/> Yes		
Special instructions (check all that apply)		
<input type="radio"/> Allergic to contrast agents	<input type="radio"/> Cardiac pacemaker	<input type="radio"/> Neurostimulators
<input type="radio"/> Aneurysm clip	<input type="radio"/> Chemotherapy	<input type="radio"/> Pregnancy
<input type="radio"/> Any metal in body	<input type="radio"/> Claustrophobic	<input type="radio"/> Renal failure/dialysis
<input type="radio"/> History of metal in eyes	<input type="radio"/> Diabetes	<input type="radio"/> Surgery in the last 6 weeks
<input type="radio"/> Orbit imaging needed	<input type="radio"/> Infusion device	<input type="radio"/> Transportation required
<input type="radio"/> Blood thinners	<input type="radio"/> Interpreter needed	<input type="radio"/> Weight consideration
<input type="radio"/> Brain or heart surgery	Language: _____	

Lab results* Creatinine _____ BUN _____ Blood draw date _____ <input type="radio"/> On-site creatinine testing needed <small>*Lab values needed within 30 days of the exam for IV contrast if the patient 1) is diabetic, 2) is 60 years or older, 3) has a history of renal failure or renal disease 4) is having chemotherapy or 5) has only one kidney.</small>			
REPORTING METHOD <input type="radio"/> Deliver CD/Images <input type="radio"/> CD/Images w/patient <input type="radio"/> Report ONLY <input type="radio"/> STAT <input type="radio"/> Read and call ASAP _____			
Provider name (print)	Phone #		Fax #
Address	City	State	Zip code
Provider signature (required) Do not use rubber stamp.	NPI # (required for new providers)	Date	Contact #

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APPLETON

201 W. Northland Ave., Suite A
Appleton, WI 54911

- High-field MRI
- High-field open MRI

For directions, visit RAYUSradiology.com.