

SCHEDULING
P: 503.253.1105
F: 503.535.8394
E: ORRAYUSorders@RAYUSradiology.com

☐ Bethany
☐ Gateway
☐ Hall/Nimbus
☐ Happy Valley
☐ Slabtown
See back for addresses

☐ Patient will call to schedule
☐ Call patient to schedule



Appointment date and time		Check-in time	Patient DOB	Sex assigned at birth <input type="radio"/> M <input type="radio"/> F
Patient name (as shown on insurance card)		Primary phone #		Secondary phone #
Insurance name		Insurance ID #		Authorization #
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private <input type="radio"/> No insurance		Date of injury	Claim #	Attorney name

(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? ☐ No ☐ Yes If yes ☐ Initial ☐ Subsequent or ☐ Sequela

Area of body ☐ R ☐ L ☐ BIL

MRI

☐ IV contrast as clinically indicated by radiologist
☐ No contrast

☐ Brain and/or ☐ Orbits ☐ Brain w/ MRA

Spine
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Upper cervical whiplash protocol

☐ Extremity _____
☐ Arthrogram _____
☐ X-ray orbits metal screening
☐ Other _____

CT

☐ IV contrast as clinically indicated by radiologist
☐ No contrast

☐ Head
☐ Sinus ☐ Maxillofacial

Dentascans
☐ Maxilla ☐ Mandible

☐ Soft tissue neck
☐ Parathyroid

☐ Lung cancer screening - use Lung Screening pad

Spine
☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Chest
☐ Calcium score screening
☐ Chest/Abdomen/Pelvis

☐ Abdomen
☐ Abdomen/Pelvis

☐ Pelvis

☐ Urogram (CT abdomen/CT pelvis)
☐ Stone protocol ☐ KUB w/ & w/o

☐ Small bowel (abdomen/pelvis) (enterography protocol)

☐ Virtual colonoscopy
☐ Screening ☐ Diagnostic

☐ Extremity _____
☐ Other _____

BREAST IMAGING

☐ L ☐ R ☐ BIL

☐ Mammogram
☐ Screening ☐ Diagnostic

☐ Proceed with additional diagnostic workup per radiologist's discretion (excludes MCR/MCD patients)

☐ Bilateral breast MRI
☐ Ultrasound

BIOPSIES/ASPIRATIONS

☐ Image-guided core biopsy
☐ Core biopsy
☐ Fine needle aspiration

Body part _____
Other _____

THERAPEUTIC PROCEDURES

☐ Image-guided joint injections
☐ Joint - specify _____

☐ Thoracentesis
☐ Paracentesis
☐ Other _____

X-RAY

Views _____

ULTRASOUND

☐ Abdomen ☐ Complete ☐ Limited _____

☐ Abdomen ☐ w/Doppler liver study ☐ w/Elastography

☐ Mesenteric

☐ Renal/Bladder ☐ Renal Artery Doppler

☐ Bladder only

☐ Prostate

☐ Pelvic w/TV if indicated

☐ Follicular

☐ OB w/TV if indicated ☐ <14 weeks ☐ 14+ weeks

☐ Lower Ext ☐ Venous ☐ Arterial

☐ Upper Ext ☐ Venous ☐ Arterial

☐ ABI

☐ Thyroid

☐ Scrotal w/Doppler if indicated

☐ Soft tissue-location _____ ☐ R ☐ L ☐ BIL

☐ Other _____

Order includes TV exam for all OB and pelvic orders, if clinically indicated. Order includes Doppler for all scrotal orders, if clinically indicated. Or opt out below.
☐ Mark this box to opt out of TV or Doppler.

FLUOROSCOPY

☐ Barium enema ☐ w/ ☐ w/o air contrast

☐ Hysterosalpingogram

☐ Upper GI ☐ w/ ☐ w/o small bowel series

☐ Barium swallow ☐ w/ ☐ w/o upper GI

☐ Voiding cystourethrogram

DXA/BMD SCAN

☐ Screening or ☐ Diagnostic

• History of pathological fracture? ☐ No ☐ Yes

• Age-related osteoporosis w/o current pathological fracture?
☐ No ☐ Yes

• Estrogen deficiency/clinical risk for osteoporosis?
☐ No ☐ Yes

• Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids? ☐ No ☐ Yes

☐ Body Composition DEXA

Prior studies ☐ No ☐ Yes Location of prior studies _____
Study read by ☐ DACBR ☐ MD radiologist
Patient consideration ☐ Sedation (administered by RAYUS Radiology) All patients receiving sedation require a driver.
Lab results Creatinine _____ BUN _____ Blood draw date _____ ☐ On-site creatinine testing needed*
*Lab values may be needed within 30 days of the exam for IV contrast if the patient: 1) is diabetic, 2) is 60 years or older, 3) is on chemotherapy, 4) has history of kidney or liver disease or 5) has hypertension

REPORTING METHOD <input type="radio"/> Report only <input type="radio"/> Report & images <input type="radio"/> Report & CD <input type="radio"/> Phone report <input type="radio"/> Fax report		
Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required)	NPI # (required for new providers)	Date
Do not use rubber stamp.		

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PATIENT PREPARATION

ARTHROGRAM • DXA SCAN • VOIDING CYSTOURETHROGRAM

No preparation is necessary.

CT • MRI

Bring prior MRI, CT or X-ray films. Call for instructions: 503.253.1105

MAMMOGRAM

Do not wear powder, deodorant or lotion.

UPPER GI/SMALL BOWEL SERIES

- Nothing to eat or drink after 10 p.m. the evening prior to the exam.
- Refrain from chewing gum or smoking until the exam is completed.
- Note: An Upper GI with small bowel series may take several hours. Average exam time is 1½ hours.

HYSTEROSALPINGOGRAM

Call the center for instructions: 503.253.1105

BARIUM ENEMA/AIR CONTRAST

The day before the exam:

- Clear liquid only, unlimited quantity. No solid foods.
- Take 5 Dulcolax tablets at 6:30 p.m.
- At 9 p.m., take a large warm water enema (one quart or more).

The day of the exam:

- Repeat enema upon rising.

ULTRASOUND

Abdomen (Exam includes liver, pancreas, aorta, gall bladder, spleen and kidneys)

- Nothing by mouth after 10 p.m. the evening prior to the exam.
- Abdominal aorta aneurysm - No food or fluids for 6 hours.

Renal

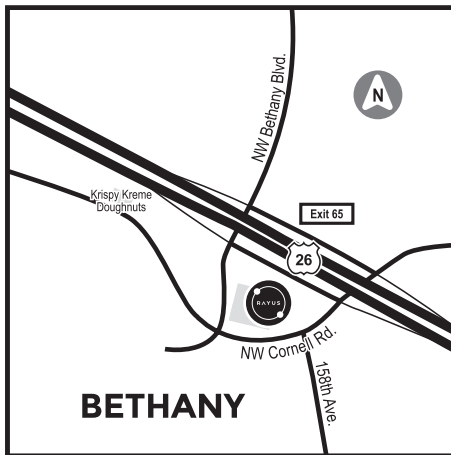
- Well hydrated.

OB/GYN (Exam includes evaluation of pregnancy, uterus, and ovaries)

- Drink 32 ounces of water one hour prior to the exam. Do not empty your bladder until the exam is completed.

Sonohysterogram

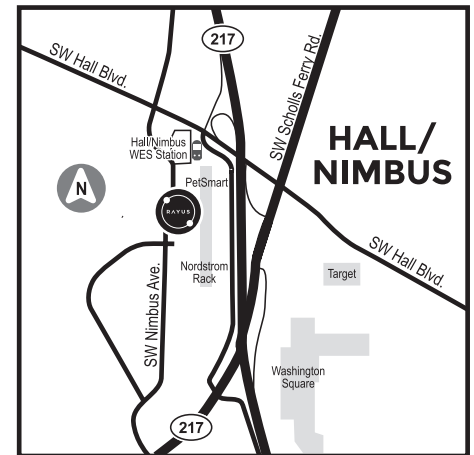
- Drink 32 ounces of water one hour prior to your exam. Do not use the restroom until you have been directed to do so by one of our staff members.



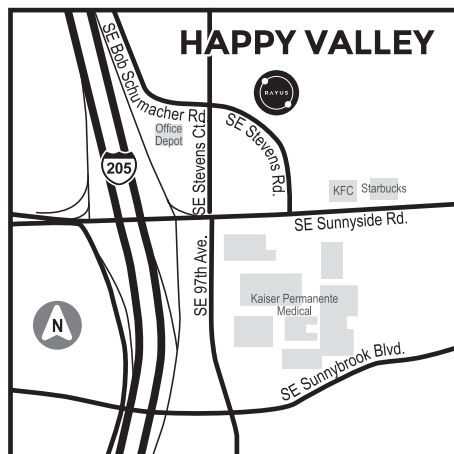
BETHANY
1500 NW Bethany Blvd., Suite 100
Beaverton, OR 97006



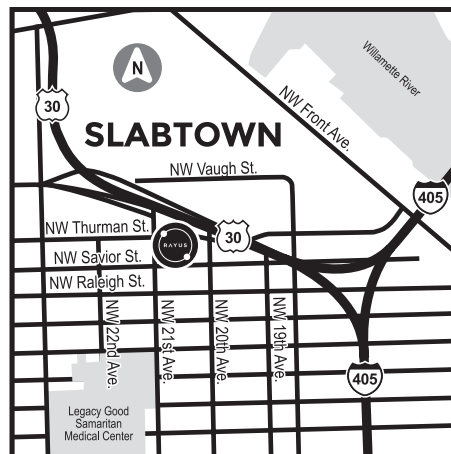
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



HALL/NIMBUS
8950 SW Nimbus Ave.
Beaverton, OR 97008



HAPPY VALLEY
10121 SE Sunnyside Rd., Suite 170
Clackamas, OR 97015



SLABTOWN
2055 NW Savor St., Suite 110
Portland, OR 97209