

SCHEDULING

P: 503.253.1105
F: 503.535.8394

E: ORRAYUSorders@RAYUSradiology.com

- Bethany
- Gateway
- Hall/Nimbus
- Happy Valley
- Slabtown

- Patient will call to schedule
- Call patient to schedule

See back for addresses



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		<input type="radio"/> OR <input type="radio"/> OL <input type="radio"/> OBL																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; background-color: black; color: white;">MRI</th> <th style="text-align: center; background-color: black; color: white;">BREAST IMAGING</th> <th style="text-align: center; background-color: black; color: white;">ULTRASOUND</th> </tr> </thead> <tbody> <tr> <td> <input type="radio"/> IV contrast as clinically indicated by radiologist <input type="radio"/> No contrast <input type="radio"/> Brain and/or <input type="radio"/> Orbita <input type="radio"/> Brain w/ MRA <input type="radio"/> Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Upper cervical whiplash protocol <input type="radio"/> Extremity _____ <input type="radio"/> Arthrogram _____ <input type="radio"/> X-ray orbits metal screening <input type="radio"/> Other _____ </td> <td> <input type="radio"/> Mammogram <input type="radio"/> Screening <input type="radio"/> Diagnostic <input type="radio"/> Proceed with additional diagnostic workup per radiologist's discretion (excludes MCR/MCD patients) <input type="radio"/> Bilateral breast MRI <input type="radio"/> Ultrasound </td> <td> <input type="radio"/> Abdomen <input type="radio"/> Complete <input type="radio"/> Limited _____ <input type="radio"/> Abdomen <input type="radio"/> w/ Doppler liver study <input type="radio"/> w/Elastography <input type="radio"/> Mesenteric <input type="radio"/> Renal/Bladder <input type="radio"/> Renal Artery Doppler <input type="radio"/> Bladder only <input type="radio"/> Prostate <input type="radio"/> Pelvic w/TV if indicated <input type="radio"/> Follicular <input type="radio"/> OB w/TV if indicated <input type="radio"/> <14 weeks <input type="radio"/> 14+ weeks <input type="radio"/> Lower Ext <input type="radio"/> Venous <input type="radio"/> Arterial <input type="radio"/> Upper Ext <input type="radio"/> Venous <input type="radio"/> Arterial <input type="radio"/> ABI <input type="radio"/> Thyroid <input type="radio"/> Scrotal w/Doppler if indicated <input type="radio"/> Soft tissue-location _____ <input type="radio"/> OR <input type="radio"/> OL <input type="radio"/> OBL <input type="radio"/> Other _____ </td> </tr> <tr> <td colspan="3" style="text-align: center; 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<input type="radio"/> Prior studies <input type="radio"/> No <input type="radio"/> Yes Location of prior studies _____ <input type="radio"/> Study read by <input type="radio"/> DACBR <input type="radio"/> MD radiologist			
<input type="radio"/> Patient consideration <input type="radio"/> Sedation (administered by RAYUS Radiology) All patients receiving sedation require a driver. <input type="radio"/> Lab results Creatinine _____ BUN _____ Blood draw date _____ <input type="radio"/> On-site creatinine testing needed*			
<small>*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</small>			
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	Phone #
Provider signature (required)		NPI # (required for new providers)	
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.

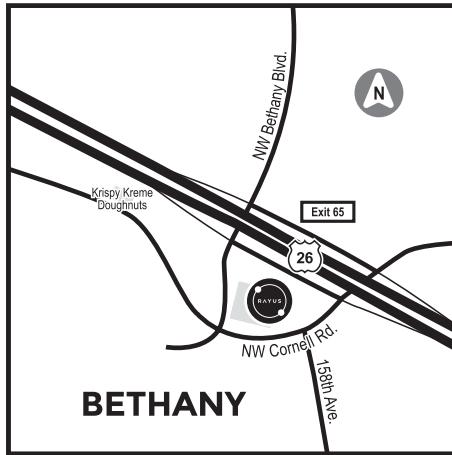
OB/GYN

 (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

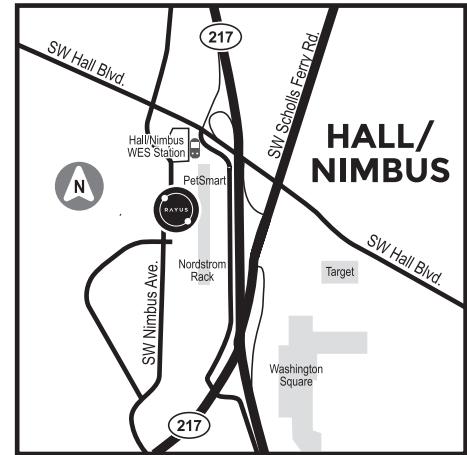
- Drink 32 ounces of water one hour prior to your exam. Do not use the restroom until you have been directed to do so by one of our staff members.



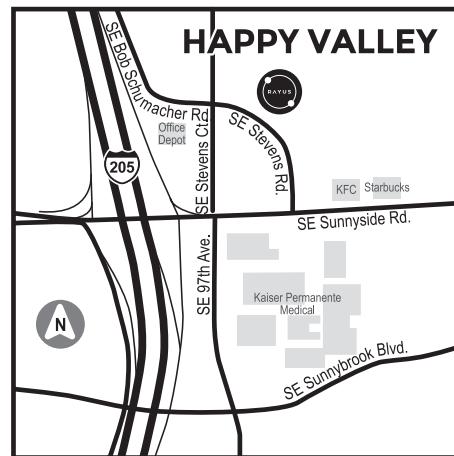
BETHANY
1500 NW Bethany Blvd., Suite 100
Beaverton, OR 97006



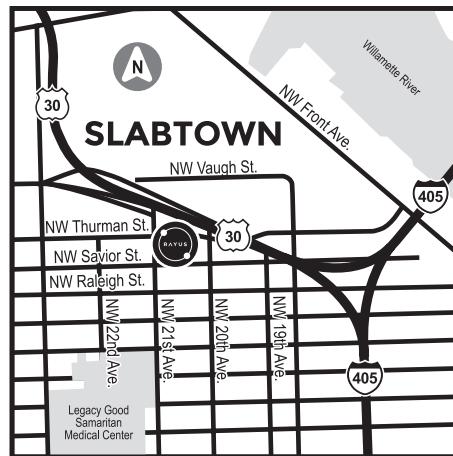
GATEWAY
233 NE 102nd Ave.
Portland, OR 97220



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



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



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