

SCHEDULING

- ☐ Patient will call to schedule
☐ Call patient to schedule

☐ **DESOTO**
☐ **MANSFIELD**
P: 214.420.5400

☐ **MCKINNEY**
☐ **PLANO**
☐ **RICHARDSON**
P: 972.920.0120

E: TXimagingorders@RAYUSradiology.com

See back for fax numbers and 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 # | Group # | |
| <input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> 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? ☐ No ☐ Yes If yes ☐ Initial ☐ Subsequent or ☐ Sequela

☐ R ☐ L ☐ BIL

MRI**CT****X-RAY**

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

- ☐ Arthrogram _____
☐ Other _____

NEURO

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

SPINE

- ☐ Cervical
☐ Thoracic
☐ Lumbar

BODY

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

UPPER**EXTREMITY**

- ☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hand

LOWER**EXTREMITY**

- ☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot

MRA

- ☐ Head
☐ Carotid
☐ Aorta w/runoff
☐ Renal

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

☐ 3D reconstructions as clinically indicated by radiologist
OR ☐ No 3D reconstructions

- ☐ Arthrogram _____
☐ Heart calcium scoring
☐ Other _____

NEURO

- ☐ Head
☐ IAC/Temporal bones
☐ Facial bones
☐ Pituitary
☐ TMJ
☐ Neck (soft tissue)
☐ Sinus

- ☐ Complete ☐ Limited

SPINE

- ☐ Cervical
☐ Thoracic
☐ Lumbar

BODY

- ☐ Chest
☐ Lung screening
☐ Abdomen
☐ Abdomen/Pelvis
☐ Enterography (abd/pel)
☐ Pelvis
☐ Hip(s)

UPPER**EXTREMITY**

- ☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hand

LOWER**EXTREMITY**

- ☐ Knee
☐ Ankle
☐ Foot

CTA

- ☐ Brain
☐ Aorta
☐ Chest
☐ Abdomen
☐ Pelvis
☐ Lung (PE)
☐ Carotid
☐ Mesenteric
☐ Renal

Views _____

☐ Skeletal survey

☐ Spine

☐ Cervical

☐ Thoracic

☐ Lumbar

☐ Scoliosis series

☐ Chest

☐ Rib series

☐ Pelvis

☐ Hip(s)

☐ Other _____

☐ Abdomen/KUB

☐ Shoulder

☐ Humerus

☐ Elbow

☐ Forearm

☐ Wrist

☐ Hand

☐ Knee

☐ Ankle

☐ Foot

ULTRASOUND

☐ Doppler if clinically indicated by radiologist
OR ☐ No Doppler

☐ Transvaginal if clinically indicated by radiologist
OR ☐ No transvaginal

☐ Abdomen complete
(diaphragm to iliac crest)

☐ Aorta

☐ Breast

☐ Carotid artery

☐ Gallbladder

☐ Liver

☐ Liver Doppler

☐ Liver w/elastography

☐ Obstetric

☐ 1st trimester

☐ 2nd trimester

☐ 3rd trimester

☐ Other _____

☐ Pelvis (Iliac crest to pubic symphysis)

☐ Renal and ☐ Bladder

☐ Scrotum ☐ Doppler

☐ Soft tissue

☐ Transvaginal

☐ Thyroid/Parathyroid

☐ Arterial Doppler

☐ Upper extremity

☐ Lower extremity

☐ Venous Doppler

☐ Upper extremity

BONE DENSITY

☐ 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

MAMMOGRAPHY 3D

☐ Screening or ☐ Diagnostic

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

Patient considerations (check all that apply) ☐ Claustrophobic ☐ Sedation (administered by RAYUS Radiology) All patients receiving sedation require a driver.

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

REPORTING METHOD

☐ STAT call # _____

☐ CD to provider's office

☐ STAT fax # _____

☐ Patient to hand carry CD/report

☐ STAT/ASAP

Provider name (print)

Provider location

City/Zip

Phone #

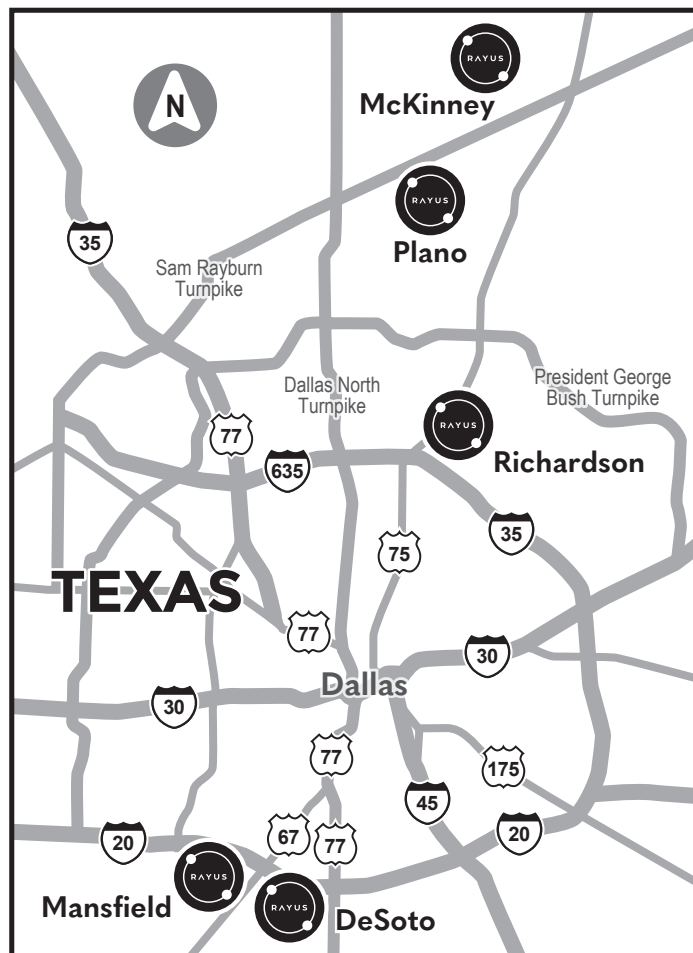
Provider signature (required)

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.



| 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 | ● (Wide-bore) | ● | ● | ● | ● | ● | 3D mammography, Bone density, Breast cancer risk assessment, Breast MRI, Biopsies |
| Mansfield | P: 214.420.5400 F: 817.453.8082 | 2975 E. Broad St., Suite 101 Mansfield, TX 76063 | ● (Open) | ● | ● | | | ● | Arthrogram |
| McKinney | P: 972.920.0120 F: 214.592.0035 | 7300 Eldorado Pkwy., Suite 170 McKinney, TX 75070 | ● (Oval) (Wide-bore) | ● | ● | ● | ● | ● | 3D mammography, Breast cancer 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, Bone density, Arthrogram |
| Richardson | P: 972.920.0120 F: 972.238.1222 | 4140 E. Renner Rd., Suite 100 Richardson, TX 75082 | ● (Open) | ● | ● | | | ● | Arthrogram |