

INTERVENTIONAL RADIOLOGY ORDER FORM

HOSPITAL IMAGING Phone 425.251.5183 • Fax 425.656.5009



PATIENT INFORMATION

Today's date: _____

Patient Name: _____ Male Female Date of Birth _____

Phone: (H) _____ (W) _____ Approx. Weight: _____ Social Security Number: _____

Exam Date & Time: _____ Date of patient's next appt. w/ physician: _____

Referring Physician (print): _____ Primary care physician (print): _____

IMPORTANT CLINICAL INFO

Reason for exam (ICD-9 Code): _____

What are the patient's known signs, symptoms, diseases? _____

What is the clinical question to be answered by this exam? _____

Relevant prior surgery/radiation? _____

Please list relevant imaging studies (CT, MRI, etc), where they were done and the exam dates _____

Any known allergies? _____

Please list patient's medications (anticoagulants only): _____

Pregnant? Yes No If Yes, how many weeks? _____ Date of LMP _____

Check all that apply:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Previous allergy to contrast | <input type="checkbox"/> Yes <input type="checkbox"/> No Hx kidney disease (need BUN/Creatinine levels)
Creatinine level: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is diabetic (need BUN/Creatinine w/in past 90 days)
Creatinine level: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Having liver, lung or kidney biopsy, will need PT/PTT |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is on Glucophage/Glucoavance or Metformin (contact office for instructions) | <input type="checkbox"/> Yes <input type="checkbox"/> No History of bleeding disorder (if yes, requires PT/PTT) |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Other outpatient services scheduled for the same day
If yes: _____ |

PROCEDURES

Biopsy/Drainage

- Biopsy: _____
- Paracentesis
- Thoracentesis
- Abscess Drainage
- Tube Checks
- Fistulogram
- Other

Vascular

- Diagnostic Angiography
- Central Line
- Thrombolysis
- Dialysis Access
- Angioplasty
- Embolization
- Other

Genitourinary

- Nephrostomy
- Stent
- Other

Biliary/GI

- Trans Hepatic Cholangiography and/or Biliary Drainage
- Tube Check
- Percutaneous Gastrostomy
- Sinogram
- Other

Specialized Procedures/Consultations

- Vertebroplasty
- UFE/UAE
- Fallopian Tube Recanalization
- Radiofrequency Ablation of Tumors
- Other

*Spinal Injections: please use spinal injection form

Specific Instructions: _____

Physician Signature (required): _____

(NOTE: Federal regulations require a physician's signature. Please send this signed form with patient or fax to 425.656.5009.)