

# Outpatient Invasive Radiology Procedure Order Form



Please complete all fields.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Patient Phone # \_\_\_\_\_  
Authorization # (primary insurance) \_\_\_\_\_ Date \_\_\_\_\_  
Authorization # (secondary insurance) \_\_\_\_\_ Date \_\_\_\_\_  
Clinical Info/Symptoms/  
Reason for Exam:  
Diagnosis Code(s): \_\_\_\_\_

Current weight: \_\_\_\_\_ Can the patient have contrast?  YES  NO

Is the patient allergic to IV contrast?  YES  NO

*If yes, patient needs to be pre-medicated per Radiology Protocol*

Is the patient taking anticoagulants/aspirin products/NSAIDs?  YES  NO *If yes, list:*

For females 12-55: Is there a chance of pregnancy?  YES  NO *If yes, date of LMP:*

## Interventional Radiology Procedure Reason for Consult:

- Embolization  Filter placement  Filter removal (*requires consult at Eastern Interventional Radiology*)
- Declot vascular device  Dialysis fistulagram/shuntagram  Abscess drain placements
- Angiogram/arteriogram  CVL placement (*tunneled line*)  CVL removal (*tunneled line*)
- Infusaport placement  Infusaport removal  Nephrostomy tube placement/exchange
- Cholecystostomy tube placement/exchange  Suprapubic catheter placement/upsite  Biopsy
- Other: \_\_\_\_\_

Does the patient have current imaging available for VIR Physician to review (CT/MRI/US/PET)?  YES  NO

## Ultrasound Invasive Procedure Order:

*(Patients MUST have previous imaging. Please call 252-847-4549 to schedule a biopsy under ultrasound guidance.)*

Imaging facility: \_\_\_\_\_

Date of study: \_\_\_\_\_ Type of study: \_\_\_\_\_

*If imaging was not done at a Power Share facility, a DICOM CD Must be sent to Imaging Informatics.*

**Paracentesis**, Reason for procedure: \_\_\_\_\_

*Are recurring paracentesis needed?*  YES  NO *How often?* \_\_\_\_\_

*Are labs needed on fluid?*  YES  NO *If yes, what labs?* \_\_\_\_\_

**Thoracentesis**, Reason for procedure: \_\_\_\_\_  Right  Left

*Are labs needed on fluid?*  YES  NO *If yes, what labs?* \_\_\_\_\_

**Joint Aspiration**, Area of interest: \_\_\_\_\_  Right  Left

*Are labs needed on fluid?*  YES  NO *If yes, what labs?* \_\_\_\_\_

**Biopsy**, Area of interest: \_\_\_\_\_  Right  Left  NA

*Reason for exam:* \_\_\_\_\_

*Are core biopsies needed?*  YES  NO

Provider signature: \_\_\_\_\_ Provider name: \_\_\_\_\_

Supervising MD/DO (*required for APP orders*): \_\_\_\_\_

Office contact name: \_\_\_\_\_ Office contact number: \_\_\_\_\_