Outpatient Invasive Radiology Procedure Order Form

ECU HEALTH

Please complete all fields.

Patient Name_____ DOB_____ Appt. Date/Time_____

Authorization # *(primary insurance)*_____ Date_____

Authorization # *(secondary insurance)*_____ Date_____

Clinical Information/Symptoms/
Reason for Exam:

Diagnosis Code(s)_____ CPT Code *(if applicable)*:_____

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/upsize ☐ 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:_____