Outpatient Invasive Radiology Procedure Order Form

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:__________