Outpatient Invasive Radiology Procedure Order Form

ECU HEALTH

Please complete all fields.

Patient Name:_____ DOB:_____ Phone:_____

Primary Insurance Provider:_____ Authorization #:_____ Authorization Date:_____

Secondary Insurance Provider:_____ Authorization #:_____ Authorization Date:_____

Clinical information/symptoms:_____

Reason for exam:_____

Diagnosis Code(s): _____ CPT Code:_____

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:_____

Note: For all invasive radiology procedure orders, please send the patient's office visit notes from within the past 30 days with your order.

Interventional Radiology Procedure Reason for Consult

☐ Embolization ☐ Filter placement ☐ Filter removal *(requires consult at Eastern Interventional Radiology)*

☐ Declot vascular device ☐ Dialysis fistulagram/shuntagram ☐ Abcess drain placements

☐ Angiogram/arteriogram ☐ CVL placement *(tunneled line)* ☐ CVL removal *(tunneled line)*

☐ Infusaport placement ☐ Infusaport removal ☐ Nephrostomy tube placement/exchange

☐ Biopsy ☐ Cholecystostomy tube placement/exchange ☐ Suprapubic catheter placement/upsize

☐ 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 252-847-9016 to schedule a procedure 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?*_____

Is Albumin needed? ☐ *YES* ☐ *NO* *If yes, how much?*_____

☐ **Thoracentesis** | Reason for procedure:_____ ☐ *R* ☐ *L*

Are labs needed on fluid? ☐ *YES* ☐ *NO* *If yes, what labs?*_____

Are recurring appointments needed? ☐ *YES* ☐ *NO* *If yes, how often?*_____

☐ **Joint Aspiration** | Area of interest:_____ ☐ *R* ☐ *L*

Are labs needed on fluid? ☐ *YES* ☐ *NO* *If yes, what labs?*_____

☐ **Biopsy** | Area of interest:_____ ☐ *R* ☐ *L* ☐ *NA*

*Reason for exam:*_____

Are core biopsies needed? ☐ *YES* ☐ *NO*

Special labs on specimen? ☐ *YES* ☐ *NO* *If yes, what labs?*_____

Continued on page 2

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Diagnostic Radiology Procedure Order

☐ Lumbar Puncture Labs needed on CSF:_____

☐ Myelogram *(will need CT as well)*: ☐ *Cervical* ☐ *Thoracic* ☐ *Lumbar* Level:_____

Vascular Access Order

☐ PICC placement Name of Home Health Agency (required for PICC placement or exchange):

☐ PICC exchange _____

Provider signature:_____ Provider name:_____

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

Office contact name:_____ Office contact number:_____