

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Patient Phone #: _____ Diagnosis Code(s): _____

*Clinical History: _____ *Please Fax Relevant Clinical Notes*

Referring Provider: _____ Provider's Signature: _____

Phone #: _____ *When faxing this form, please include a copy of patient's insurance card & face sheet.*

Does the patient require Sedation or Anesthesia? ☐ NO ☐ Sedation ☐ Anesthesia ☐ Yes, ≤ 17 years old (Interventional Radiology Procedures)

Check to approve Point of Care Testing necessary to proceed with imaging:

☐ Radiology Creatinine (POCT) ☐ Radiology Pregnancy Test (POCT)

INTERVENTIONAL RADIOLOGY (MAIN CAMPUS AND BAIRD VASCULAR INSTITUTE)

PHONE: 804.827.2329 & FAX: 804.628.9929

LEGEND

SL = Single Lumen
DL = Double Lumen
TL = Triple Lumen

R = Right
L = Left
B = Bilateral

UE = Upper Extremity
LE = Lower Extremity
PICC = Peripherally Inserted Central Catheter

PROCEDURES

- ☐ Arteriogram ☐ R ☐ L ☐ B ☐ UE ☐ LE
☐ With Embolization or Other _____
☐ With Intervention or Other _____
☐ Arterio Venous Fistula Declot ☐ R ☐ L ☐ B ☐ UE ☐ LE
☐ Arterio Venous Fistulogram ☐ R ☐ L ☐ B ☐ UE ☐ LE
☐ Biliary Catheter Check/Change
☐ CT Guided Plexus Block ☐ Celiac ☐ Hypogastric
☐ Dialysis/Apheresis Catheter Placement
Tunneled or Non-Tunneled
☐ Drug Eluting Bead Embolization ☐ R ☐ L
☐ Endovenous Thermal Ablation ☐ R ☐ L
☐ Gastrostomy Change
☐ Gastrostomy Placement
☐ Gastrojejunostomy Tube Change
☐ Gastrojejunostomy Tube Placement
☐ Hickman Placement ☐ SL ☐ DL
☐ Inferior Vena Cava Filter Placement
☐ Inferior Vena Cava Filter Retrieval
☐ Percutaneous Nephrostomy / NephroUreteral Stent Placement ☐ R ☐ L ☐ B
☐ Percutaneous Nephrostomy / NephroUreteral Checked or Changed ☐ R ☐ L ☐ B
☐ Percutaneous Transhepatic Cholangiogram with Drainage
☐ PICC Change ☐ SL ☐ DL ☐ TL
☐ PICC Placement ☐ SL ☐ DL ☐ TL
☐ Portacath Placement ☐ SL ☐ DL
☐ Power ☐ Vortex ☐ PowerFlow
☐ Portacath Removal
☐ Powerline Placement ☐ SL ☐ DL
☐ Transjugular Intrahepatic Portosystemic Shunt or TIPS Follow-Up
☐ Transvascular Biopsy with Pressures ☐ Liver ☐ Kidney
☐ Tunneled Catheter Removal
☐ Venogram ☐ R ☐ L ☐ B ☐ UE ☐ LE
Other Venogram: _____

SPECIAL VASCULAR PROCEDURES

- ☐ Varicose Vein ☐ R ☐ L ☐ B ☐ UE ☐ LE
☐ EVTA ☐ AP ☐ USGFS
☐ Tenotomy/Fasciotomy ☐ R ☐ L ☐ B
☐ Plantar ☐ Elbow ☐ Achilles

CONSULT

- ☐ Endovenous Thermal Ablation ☐ R ☐ L
☐ Kyphoplasty Circle level(s) below:
Lumbar 1 2 3 4 5
Thoracic 5 6 7 8 9 10 11 12
☐ RadioFrequency Ablation/Cryoablation
☐ Liver ☐ R ☐ L
☐ Kidney ☐ R ☐ L
☐ Lung ☐ R ☐ L
☐ Therasphere ☐ R ☐ L
☐ LC Bead
☐ Uterine Fibroid Embolization
☐ Other: _____

NON-VASCULAR INTERVENTIONAL RADIOLOGY

PHONE: 804.827.4787 & FAX: 804.828.5570

☐ I agree to FL/US/CT guidance for aspiration, biopsy or drainage catheter placement as deemed medically necessary indicated by the radiologist or advance practice provider.

CT/ULTRASOUND/FLUORO GUIDED PROCEDURES

- ☐ Bone/Soft Tissue ☐ Kidney
☐ Paracentesis ☐ Lung
☐ Thoracentesis ☐ Thyroid
☐ Pancreas ☐ Prostate
☐ Fluid Collection/Abscess Drainage ☐ Lumason Contrast Study _____
☐ Liver _____
☐ CT Virtual Colonography ☐ Other: _____
☐ Diagnostic ☐ Screening

PROCEDURE TYPE

- ☐ Biopsy
☐ Botox Injection
☐ Drainage/Aspiration
☐ Aspira Catheter
☐ Radiofrequency Ablation (Bone) _____
☐ Pudendal Nerve Block
☐ Specific Location of Procedure/Study: _____

MUSCULOSKELETAL MINOR PROCEDURES AND INJECTIONS

PHONE: 804.828.1436 & FAX: 804.628.0792

EXTREMITY PROCEDURES

- Arthrogram**
☐ Conventional
☐ With MRI
☐ With CT
☐ LEFT ☐ RIGHT
☐ Wrist
☐ Elbow
☐ Hip
☐ Knee
☐ Shoulder
☐ Ankle
Joint Injection
☐ Marcaine
☐ Steroid
☐ LEFT ☐ RIGHT
☐ Wrist
☐ Elbow
☐ Hip
☐ Knee
☐ Shoulder
☐ Ankle

- Joint Aspiration**
☐ Culture & Sensitivity
☐ Cell Count
☐ Fluid Analysis-Crystals
☐ LEFT ☐ RIGHT
☐ Wrist
☐ Elbow
☐ Hip
☐ Knee
☐ Shoulder
☐ Ankle

SPINE PROCEDURES

- SI Joint Injection**
L1-2 ☐ LEFT ☐ RIGHT
L2-3 ☐ LEFT ☐ RIGHT
L3-4 ☐ LEFT ☐ RIGHT
L4-5 ☐ LEFT ☐ RIGHT
L5-S1 ☐ LEFT ☐ RIGHT
S1 ☐ LEFT ☐ RIGHT
Epidural Steroid Injection
☐ Interlaminar
☐ Transforaminal/Selective Nerve Root
☐ Facet Injection

NEURO RADIOLOGY / MYELOGRAMS / LUMBAR PUNCTURES

PHONE: 804.827.4787 & FAX: 804.828.5570

FLUORO GUIDED PROCEDURES

- ☐ Cervical Myelogram ☐ Lumbar Puncture
☐ Lumbar Myelogram ☐ Other:
☐ Thoracic Myelogram

Medical Records Copy
HM-R 1914 (rev. 05-21)



DT-ORDER