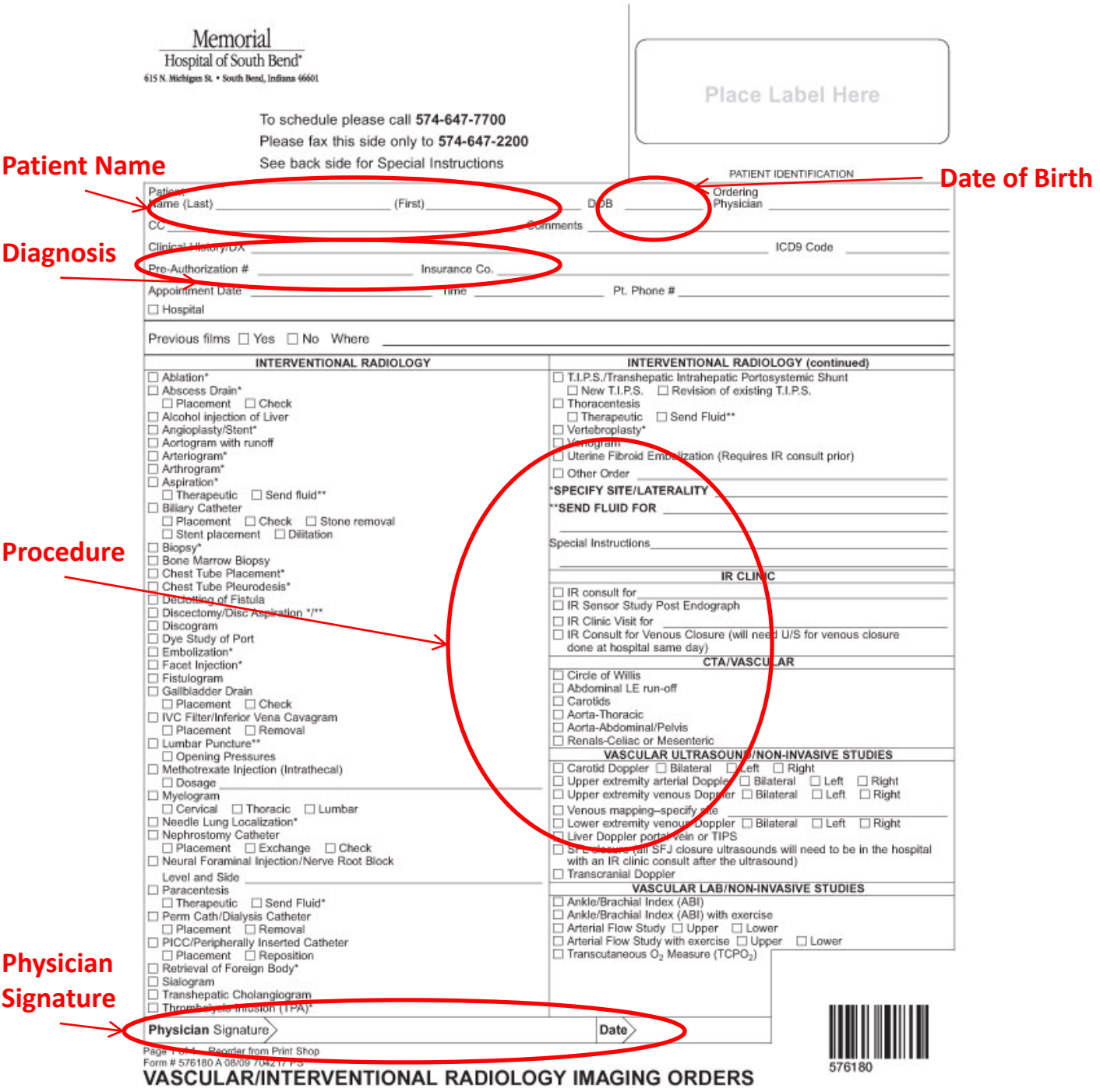
Vascular/Interventional Radiology Order Form



Memorial
Hospital of South Bend*
615 N. Michigan St. • South Bend, Indiana 46601

Place Label Here

To schedule please call **574-647-7700**
Please fax this side only to **574-647-2200**
See back side for Special Instructions

PATIENT IDENTIFICATION

Patient Name (Last) _____ (First) _____ DOB _____ Ordering Physician _____
CC _____ Comments _____
Clinical History/DX _____ ICD9 Code _____
Pre-Authorization # _____ Insurance Co. _____
Appointment Date _____ Time _____ Pt. Phone # _____
☐ Hospital

Previous films ☐ Yes ☐ No Where _____

INTERVENTIONAL RADIOLOGY

☐ Ablation*
☐ Abscess Drain*
☐ Placement ☐ Check
☐ Alcohol injection of Liver
☐ Angioplasty/Stent*
☐ Aortogram with runoff
☐ Arteriogram*
☐ Arthrogram*
☐ Aspiration*
☐ Therapeutic ☐ Send fluid**
☐ Biliary Catheter
☐ Placement ☐ Check ☐ Stone removal
☐ Stent placement ☐ Dilitation
☐ Biopsy*
☐ Bone Marrow Biopsy
☐ Chest Tube Placement*
☐ Chest Tube Pleurodesis*
☐ Declotting of Fistula
☐ Discectomy/Disc Aspiration */**
☐ Discogram
☐ Dye Study of Port
☐ Embolization*
☐ Facet Injection*
☐ Fistulogram
☐ Gallbladder Drain
☐ Placement ☐ Check
☐ IVC Filter/Inferior Vena Cavagram
☐ Placement ☐ Removal
☐ Lumbar Puncture**
☐ Opening Pressures
☐ Methotrexate Injection (Intrathecal)
☐ Dosage _____
☐ Myelogram
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Needle Lung Localization*
☐ Nephrostomy Catheter
☐ Placement ☐ Exchange ☐ Check
☐ Neural Foraminal Injection/Nerve Root Block
Level and Side _____
☐ Paracentesis
☐ Therapeutic ☐ Send Fluid*
☐ Perm Cath/Dialysis Catheter
☐ Placement ☐ Removal
☐ PICC/Peripherally Inserted Catheter
☐ Placement ☐ Reposition
☐ Retrieval of Foreign Body*
☐ Sialogram
☐ Transhepatic Cholangiogram
☐ Thrombolysis Infusion (TPA)*

INTERVENTIONAL RADIOLOGY (continued)

☐ T.I.P.S./Transhepatic Intrahepatic Portosystemic Shunt
☐ New T.I.P.S. ☐ Revision of existing T.I.P.S.
☐ Thoracentesis
☐ Therapeutic ☐ Send Fluid**
☐ Vertebroplasty*
☐ Venogram
☐ Uterine Fibroid Embolization (Requires IR consult prior)
☐ Other Order _____
*SPECIFY SITE/LATERALITY _____
**SEND FLUID FOR _____
_____
Special Instructions _____
_____

IR CLINIC

☐ IR consult for _____
☐ IR Sensor Study Post Endograph
☐ IR Clinic Visit for _____
☐ IR Consult for Venous Closure (will need U/S for venous closure done at hospital same day)

CTA/VASCULAR

☐ Circle of Willis
☐ Abdominal LE run-off
☐ Carotids
☐ Aorta-Thoracic
☐ Aorta-Abdominal/Pelvis
☐ Renals-Celiac or Mesenteric

VASCULAR ULTRASOUND/NON-INVASIVE STUDIES

☐ Carotid Doppler ☐ Bilateral ☐ Left ☐ Right
☐ Upper extremity arterial Doppler ☐ Bilateral ☐ Left ☐ Right
☐ Upper extremity venous Doppler ☐ Bilateral ☐ Left ☐ Right
☐ Venous mapping–specify site _____
☐ Lower extremity venous Doppler ☐ Bilateral ☐ Left ☐ Right
☐ Liver Doppler portal vein or TIPS
☐ SFJ closure (all SFJ closure ultrasounds will need to be in the hospital with an IR clinic consult after the ultrasound)
☐ Transcranial Doppler

VASCULAR LAB/NON-INVASIVE STUDIES

☐ Ankle/Brachial Index (ABI)
☐ Ankle/Brachial Index (ABI) with exercise
☐ Arterial Flow Study ☐ Upper ☐ Lower
☐ Arterial Flow Study with exercise ☐ Upper ☐ Lower
☐ Transcutaneous O_2 Measure ($TCPO_2$)

Physician Signature _____ Date _____

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Form # 576180 A 08/09 704217 PS

576180

VASCULAR/INTERVENTIONAL RADIOLOGY IMAGING ORDERS

Patient Name

Diagnosis

Procedure

Physician Signature

Date of Birth

A valid order must be legible and include:

- Patient Name
- Date of Birth
- Diagnosis
- Procedure
- Physician Signature (a stamp or nurse signature ***is not acceptable*** per Medicare regulations)