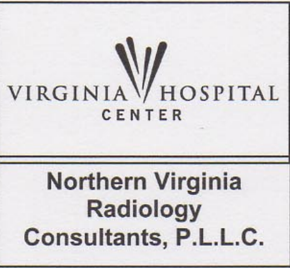
Interventional Radiology: Procedure Request Form



Northern Virginia Radiology Consultants, P.L.L.C.

PATIENT NAME ____________________ DATE OF BIRTH ____________

CLINICAL HISTORY / SYMPTOMS ____________________

SPECIAL REQUESTS / AUTHORIZATION NUMBER ____________________

REFERRING PHYSICIAN NAME ____________________ PHONE ____________

REFERRING PHYSICIAN SIGNATURE ____________________ DATE ____________

Allergy to Iodine ☐ YES ☐ NO **CREATNINE** ____________ **DATE DRAWN** ____________

PHYSICIANS:

1. Please fax to **703.558.6252** AND give a copy of this form to the patient.

2. Please have the patient call **703.558.6533** to schedule their appointment

OR

☐ Check here if you would prefer to have our scheduling department contact your patient for scheduling.

PLEASE PROVIDE PATIENT'S PHONE# ____________

PATIENTS

1. All Procedures require advanced scheduling, registration and instructions.

2. Call **703.558.6533** if you have not been contacted in 48 hours.

3. **BRING THIS FORM WITH YOU ON THE DAY OF YOUR EXAM!**

Interventional Radiology Scheduling Phone: 703.558.6533 Fax: 703.558.6252

PAIN MANAGEMENT

- ☐ SI Injection
- ☐ Caudal Block
- ☐ Facet Injection
- ☐ Celiac Plexus Neurolysis
- ☐ Other ____________________

Joint Injections

- ☐ Arthrogram
- ☐ MRI Arthrogram
- ☐ With Steroid
- ☐ With Anesthetic

Joint	R	L
☐ Shoulder	R___	L___
☐ Elbow	R___	L___
☐ Wrist	R___	L___
☐ Hip	R___	L___
☐ Knee	R___	L___
☐ Ankle	R___	L___

TUBES/ DRAINS

- ☐ Biliary
- ☐ Chest Tube
- ☐ Cholecystotstomy
- ☐ Abcess
- ☐ Gastrostomy
- ☐ G-J
- ☐ Nephrostomy
- ☐ Biliary Tube Removal
- ☐ Chest Tube Removal
- ☐ G-tube Removal
- ☐ G/J-tube Removal
- ☐ Nephrostomy tube Removal

Other ____________________

BIOPSY

- ☐ Abdominal Mass
- ☐ Renal
- ☐ Liver
- ☐ Lung
- ☐ Fiducial Placement
- ☐ Axillary Node
- ☐ Bone Biopsy
- ☐ Thyroid Biopsy
- ☐ Other ____________________

PRIOR STUDIES ____________

VENOUS ACCESS

- ☐ PICC Line
- ☐ Mediport
- ☐ Mediport Evaluation
- ☐ Permacath
- ☐ Groshong Catheter
- ☐ AV Fistulagram
- ☐ PICC Line Removal
- ☐ Mediport Removal
- ☐ Permacath Evaluation
- ☐ Permacath Removal
- ☐ Groshong Removal
- ☐ Other ____________

CONSULTATION

- ☐ Angiogram
- ☐ Angioplasty/Stenting
- ☐ Aortic Endograft
- ☐ Chemo Embolization
- ☐ Kyphoplasty
- ☐ Ovarian Vein Embolization
- ☐ Tumor Radiofrequency Ablation
- ☐ TIPS
- ☐ Uterine Artery Embolization
- ☐ Varicocele
- ☐ Venogram
- ☐ OTHER (specify) ____________________

OTHER

- ☐ Cisternogram
- ☐ Fallopian Tube Recannulization
- ☐ HSG
- ☐ IVC Filter
- ☐ IVC Filter Removal
- ☐ Lumbar Puncture
- ☐ Myelogram
- ☐ Paracentesis
- ☐ Thoracentesis
- ☐ Sialogram
- ☐ OTHER (specify) ____________________

PLEASE CALL 703.558.6533 TO SCHEDULE YOUR APPOINTMENT