

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone#: _____

Parent name (if patient is a minor): _____

Date: _____

Ordering Provider (PRINT): _____

Ordering Providers Signature: _____

CC Provider: _____

Phone: _____

Please specify ICD-10 and narrative diagnosis:

(Do not use unspecified, rule out, probable, possible, suspected or routine)

☐ **STAT: Immediate Fax**
Provider number to contact for critical results:

Sedation or Anesthesia Requires H&P dated within the past 30 days

CT

(or US per Radiologist discretion)

- | | | |
|--|---|---|
| ☐ Calcium Scoring | ☐ Biopsy w/ Sedation
Location: _____ | ☐ Nephrostomy |
| ☐ Coronary Arteries | ☐ Aspiration
Location: _____ | ☐ Chest Tube Insertion |
| ☐ w/ Calcium Scoring | ☐ Percutaneous Abscess Drain:
Location: _____ | ☐ TAVR |
| ☐ w/o Calcium Scoring | | ☐ Cystogram Contrast |
| ☐ Therapy Planning | | ☐ Angio Chest (Gated) |
| ☐ Heart Structures & Morphology | | |

Ultrasound

(or CT per Radiologist discretion)

- | | | |
|---|--|--|
| ☐ Liver Biopsy w/ Sedation
☐ w/ Abdomen Complete | ☐ Other Biopsy w/ Sedation
Location: _____ | ☐ Abscess Drain Guidance
Location: _____ |
| ☐ Renal Biopsy w/ Sedation | ☐ Pseudoaneurysm Repair (Thrombin Injection) | |

X-Ray

- | | | |
|---|---|---|
| ☐ G/J Tube Exchange / Check / Removal | ☐ Epidural Steroid Injection - Lumbar Midline Only
Level: _____ | ☐ Blood Patch |
| ☐ G-Tube Exchange / Check / Removal | | ☐ Intrathecal Chemotherapy |
| ☐ NG Tube Exchange / Check | | ☐ Modified Barium Swallow |
| ☐ J-Tube Exchange / Check / Removal | ☐ Lumbar Puncture | ☐ Pediatric Modified Barium Swallow
(Call McGrane Center at 208-625-5356) |
| ☐ Myelogram w/ Sedation
Cervical / Thoracic / Lumbar | *Complete the Body Fluid Test Request*
therapeutic / diagnostic / with PT | |

Interventional Radiology

Port ☐ Chest ☐ Arm PICC Lines ☐ Tunneled IJ ☐ Non-Tunneled Catheters ☐ Tunneled ☐ Non-Tunneled ☐ Pleurex Catheter	Insertion / Removal ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Nephrostomy Tube ☐ Insertion ☐ Removal ☐ Change ☐ Left ☐ Right Biliary Drain ☐ Insertion ☐ Removal ☐ Change Gastric Tube ☐ G - Tube Placement/Upsize ☐ G/J - Tube Placement/Upsize ☐ G to G/J Conversion Other: ☐ Fistulagram ☐ Transjugular Liver Biopsy ☐ Foreign Body Removal	*Pre-Procedure Consultation with radiologist required for these procedures. Order for consultation includes any recommended pre/ post procedural imaging studies ☐ Y-90* ☐ Chemoembolization* ☐ TIPS Procedure* ☐ TIPS Revision* ☐ Uterine Fibroid Embolization* ☐ Vena Cava Filter (IVC) Placement ☐ Vena Cava Filter (IVC) Removal ☐ CT Guided Celiac Plexus Block ☐ Kyphoplasty/Vertebroplasty* Level: _____ ☐ Cryoablation/Microwave Ablation* Location: _____ ☐ Pluvicto ☐ Other: _____	Angio* ☐ Visceral Abdomen / Pelvis ☐ Carotid / Cerebral ☐ Renal Arteries ☐ Chest Extremity ☐ Upper Left ☐ Upper Right ☐ Lower Left ☐ Lower Right Visceral ☐ Aorta ☐ Pulmonary Venography* Extremity ☐ Upper Left ☐ Upper Right ☐ Lower Left ☐ Lower Right
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Comments: _____

PLACE PATIENT STICKER HERE

