Interventional Radiology Request Form

Office # 718-270-8292/8293
Fax # 718-270-4663

Patient Name (last name first) ______________________________ M / F

Request Date ______________ Time: ____________ D.O.B. ____/____/____

Address ______________________________ Medical Record #:____________

______________________________ Location: NS & Room #__________

Outpatient: Telephone/Cell Number ______________

Can Pt give consent - YES / NO (please complete the next item)

Health Care Proxy name & contact______________________________

Urgency: **STAT** or **TODAY** (Must discuss directly with IR attending)

Requested Procedure: ______________________________

Diagnosis: ______________________ Indication______________________

Pt hx and findings (please print clearly______________________________

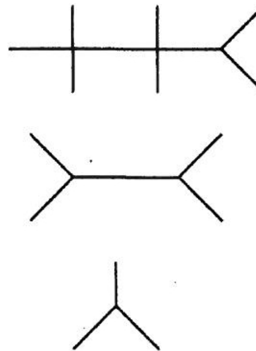
____

____

Other Meds ______________________________

ATTENDING NOTES:

Labs: Indicate date of labs



Allergies:______________________

Isolation Contact Respiratory	Yes	No
Contrast Allergies	Yes	No
Pt. intubated?	Yes	No
Coumadin	Yes	No
Heparin	Yes	No
Lovenox	Yes	No
Plavix	Yes	No
Glucophage (metformin)	Yes	No
Aspirin (81mg/325mg)	Yes	No

CPT______________

ICD-9 ______________
Date/time scheduled______________

Resident/P.A.______________________ Pager______________________

Attending MD______________________ Office/Pager______________________

PILOT 4/09