UMC HEALTH SYSTEM

INTERVENTIONAL RADIOLOGY
INVASIVE PROCEDURE CONSULT FORM

Name: _____

MRN: _____

DOB: _____ **Date:** _____

Insurance: _____

Interventional Radiology Scheduling Number: (806) 775-8770; Fax Number: (806) 775-8719

INTERVENTIONAL RADIOLOGY INVASIVE PROCEDURE CONSULT FORM

Special Instructions: Patients must be NPO after midnight the night before the procedure and arrive 1 hour prior to procedure time. Paracentesis/Thoracentesis/Thyroids do not require patients to be NPO.

(All procedures will be reviewed by Interventional Radiologist prior to scheduling)

- ❑ Abdominal/Retroperitoneal Mass Biopsy
- ❑ Ablation of _____(Microwave/Cryo)
- ❑ Abscess Drain: Location: _____
- ❑ Adrenal Biopsy (Right or Left)
- ❑ Angiogram (Hepatic/Mesenteric/Pelvic/Renal/Splenic)
- ❑ Angiogram (Upper Extremity/Lower Extremity)(Right or Left or Bilateral)
- ❑ Biliary Drain (Placement/Exchange)
- ❑ Bone Biopsy: Location: _____
- ❑ Cerebral/Carotid Angiogram
- ❑ Chest Tube (Placement/Exchange/Removal)
- ❑ Cholecystostomy Drain (Placement/Exchange/Removal)
- ❑ Fistulogram/AV Declot (Right or Left)
- ❑ G-Tube/J-Tube/G-J Tube Replacement
- ❑ IVC Filter (Placement/Removal)
- ❑ Kyphoplasty/Vertebroplasty:Level(s):_____
- ❑ Liver Biopsy (Percutaneous/Transjugular)
- ❑ Liver Chemo Embolization/TACE
- ❑ Lung Biopsy (Right or Left)
- ❑ Lymph Node Biopsy:Location:_____
- ❑ Mediastinal Mass Biopsy
- ❑ Neck Mass Biopsy
- ❑ Nephrostomy Tube (Placement/Exchange)(Right or Left or Bilateral)
- ❑ Paracentesis (Please specify if labs on fluid req)
- ❑ Pelvic Mass Biopsy
- ❑ Peripherally Inserted Central Catheter (PICC)
- ❑ Pleurx (Pleural/Peritoneal)(Right or Left)
- ❑ Port (Placement/Removal)
- ❑ Renal Biopsy (Right or Left)
- ❑ Thoracentesis (Please specify if labs on fluid req)
- ❑ Thyroid Biopsy
- ❑ Transjugular Intrahepatic Portosystemic Shunt (TIPS)
- ❑ Tunneled Catheter
- ❑ Tunneled Dialysis Catheter
- ❑ Ureteral Stents (Right or Left or Bilateral)
- ❑ Y-90 Procedure

Other Procedure Not Listed: _____

Diagnosis/Signs & Symptoms: _____

(Must have a diagnosis/signs & symptoms listed)

_____**Labs:** **(please send patient for CBC, BMP, PT/INR)**

Determine if patient is taking an anti-platelet or anti-coagulant (i.e. warfarin, apixaban, aspirin , dabigatran, etc.)
Contact Interventional Radiology for holding instructions.

_____**H&P** **(Must be within 30 days of scheduled procedure & faxed along w/order request)**

Allergies: _____

Any Images to support findings: UMC Films: _____ **Outside Films:** _____

Referring Clinic & Physician: _____

Clinic Contact Name & Number: _____

****UMC Interventional Radiology Will Call Patient Directly With Procedure Date and Time****

***Physician Signature** _____ **Date/Time** _____

**** Physician signature required***

1201