VCU Health — Interventional Radiology & Invasive Procedures Request

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Patient Phone #: _____ **Diagnosis Code(s):** _____

Clinical History:** _____ ***Please Fax Relevant Clinical Notes

Referring Provider: _____ **Provider's Signature:** _____

Phone #: _____ ***When faxing this form, please include a copy of patient's insurance card & face sheet.***

Does the patient require Sedation or Anesthesia? ☐ **NO** ☐ **Sedation** ☐ **Anesthesia** ☐ **Yes, ≤ 17 years old (Interventional Radiology Procedures)**

Check to approve Point of Care Testing necessary to proceed with imaging:

☐ **Radiology Creatinine (POCT)** ☐ **Radiology Pregnancy Test (POCT)**

INTERVENTIONAL RADIOLOGY (MAIN CAMPUS AND BAIRD VASCULAR INSTITUTE)

PHONE: 804.828.2600 & FAX: 804.828.5544

LEGEND

SL = Single Lumen | **DL = Double Lumen** | **TL = Triple Lumen**

R = Right | **L = Left** | **B = Bilateral**

UE = Upper Extremity | **LE = Lower Extremity** | **PICC = Peripherally Inserted Central Catheter**

PROCEDURES

- ☐ Arteriogram ☐ **R** ☐ **L** ☐ **B** ☐ **UE** ☐ **LE**
  - ☐ With Embolization or Other _____
  - ☐ With Intervention or Other _____
- ☐ Arterio Venous Fistula Declot ☐ **R** ☐ **L** ☐ **B** ☐ **UE** ☐ **LE**
- ☐ Arterio Venous Fistulogram ☐ **R** ☐ **L** ☐ **B** ☐ **UE** ☐ **LE**
- ☐ Biliary Catheter Check/Change
- ☐ CT Guided Plexus Block ☐ **Celiac** ☐ **Hypogastric**
- ☐ Dialysis/Aphresis Catheter Placement Tunneled or Non-Tunneled
- ☐ Drug Eluting Bead Embolization ☐ **R** ☐ **L**
- ☐ Endovenous Thermal Ablation ☐ **R** ☐ **L**
- ☐ Gastrostomy Change
- ☐ Gastrostomy Placement
- ☐ Gastrojejunostomy Tube Change
- ☐ Gastrojejunostomy Tube Placement
- ☐ Hickman Placement ☐ **SL** ☐ **DL**
- ☐ Inferior Vena Cava Filter Placement
- ☐ Inferior Vena Cava Filter Retrieval
- ☐ Percutaneous Nephrostomy / NephroUreteral Stent Placement ☐ **R** ☐ **L** ☐ **B**
- ☐ Percutaneous Nephrostomy / NephroUreteral Checked or Changed ☐ **R** ☐ **L** ☐ **B**
- ☐ Percutaneous Transhepatic Cholangiogram with Drainage
- ☐ PICC Change ☐ **SL** ☐ **DL** ☐ **TL**
- ☐ PICC Placement ☐ **SL** ☐ **DL** ☐ **TL**
- ☐ Portacath Placement ☐ **SL** ☐ **DL** ☐ **Power** ☐ **Vortex** ☐ **PowerFlow**
- ☐ Portacath Removal
- ☐ Powerline Placement ☐ **SL** ☐ **DL**
- ☐ Transjugular Intrahepatic Portosystemic Shunt or TIPS Follow-Up
- ☐ Transvascular Biopsy with Pressures ☐ **Liver** ☐ **Kidney**
- ☐ Tunneled Catheter Removal
- ☐ Venogram ☐ **R** ☐ **L** ☐ **B** ☐ **UE** ☐ **LE**
  Other Venogram: _____

SPECIAL VASCULAR PROCEDURES

- ☐ Varicose Vein ☐ **R** ☐ **L** ☐ **B** ☐ **UE** ☐ **LE** ☐ **EVTA** ☐ **AP** ☐ **USGFS**
- ☐ Tenotomy/Fasciotomy ☐ **R** ☐ **L** ☐ **B** ☐ **Plantar** ☐ **Elbow** ☐ **Achilles**

CONSULT

- ☐ Endovenous Thermal Ablation ☐ **R** ☐ **L**
- ☐ Kyphoplasty Circle level(s) below: **Lumbar 1 2 3 4 5** **Thoracic 5 6 7 8 9 10 11 12**
- ☐ RadioFrequency Ablation/Cryoablation
  - ☐ Liver ☐ **R** ☐ **L**
  - ☐ Kidney ☐ **R** ☐ **L**
  - ☐ Lung ☐ **R** ☐ **L**
- ☐ Therasphere ☐ **R** ☐ **L**
- ☐ LC Bead
- ☐ Uterine Fibroid Embolization
- ☐ Other: _____

NON-VASCULAR INTERVENTIONAL RADIOLOGY

PHONE: 804.827.4787 & FAX: 804.828.5570

☐ ***I agree to FL/US/CT guidance for aspiration, biopsy or drainage catheter placement as deemed medically necessary indicated by the radiologist or advance practice provider.***

CT/ULTRASOUND/FLUORO GUIDED PROCEDURES

- ☐ Bone/Soft Tissue
- ☐ Paracentesis
- ☐ Thoracentesis
- ☐ Pancreas
- ☐ Fluid Collection/Abscess Drainage
- ☐ Liver
- ☐ CT Virtual Colonography ☐ **Diagnostic** ☐ **Screening**
- ☐ Kidney
- ☐ Lung
- ☐ Thyroid
- ☐ Prostate
- ☐ Lumason Contrast Study _____
- ☐ Other: _____

PROCEDURE TYPE

- ☐ Biopsy
- ☐ Botox Injection
- ☐ Drainage/Aspiration
- ☐ Aspira Catheter
- ☐ Radiofrequency Ablation (Bone) _____
- ☐ Pudendal Nerve Block
- ☐ Specific Location of Procedure/Study: _____

MUSCULOSKELETAL MINOR PROCEDURES AND INJECTIONS

PHONE: 804.828.1436 & FAX: 804.628.0792

EXTREMITY PROCEDURES

Arthrogram

- ☐ Conventional
- ☐ With MRI
- ☐ With CT

☐ **LEFT** ☐ **RIGHT**

- ☐ Wrist
- ☐ Elbow
- ☐ Hip
- ☐ Knee
- ☐ Shoulder
- ☐ Ankle

Joint Injection

- ☐ Marcaine
- ☐ Steroid

☐ **LEFT** ☐ **RIGHT**

- ☐ Wrist
- ☐ Elbow
- ☐ Hip
- ☐ Knee
- ☐ Shoulder
- ☐ Ankle

Joint Aspiration

- ☐ Culture & Sensitivity
- ☐ Cell Count
- ☐ Fluid Analysis-Crystals

☐ **LEFT** ☐ **RIGHT**

- ☐ Wrist
- ☐ Elbow
- ☐ Hip
- ☐ Knee
- ☐ Shoulder
- ☐ Ankle

SPINE PROCEDURES

SI Joint Injection

L1-2	☐ LEFT	☐ RIGHT
L2-3	☐ LEFT	☐ RIGHT
L3-4	☐ LEFT	☐ RIGHT
L4-5	☐ LEFT	☐ RIGHT
L5-S1	☐ LEFT	☐ RIGHT
S1	☐ LEFT	☐ RIGHT

Epidural Steroid Injection

- ☐ Interlaminar
- ☐ Transforaminal/Selective Nerve Root

☐ **Facet Injection**

NEURO RADIOLOGY / MYELOGRAMS / LUMBAR PUNCTURES

PHONE: 804.827.4787 & FAX: 804.828.5570

FLUORO GUIDED PROCEDURES

- ☐ Cervical Myelogram
- ☐ Lumbar Myelogram
- ☐ Thoracic Myelogram
- ☐ Lumbar Puncture
- ☐ Other:

Medical Records Copy
HM-R 1914 (rev. 05-21)

DT-ORDER

http://www.vcuhealth.org/services/radiology