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: 804.827.2329 & FAX: 804.628.9929

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: 804.956.0855

ARTHROGRAM

- ☐With MRI
- ☐With CT

☐LEFT ☐RIGHT

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

JOINT INJECTION

*Specify Joint(s)

- ☐Steroid

☐LEFT ☐RIGHT

- ☐Wrist* _____
- ☐Elbow
- ☐Hip* _____
- ☐Knee* _____
- ☐Shoulder
- ☐Ankle* _____
- ☐Foot* _____
- ☐SI Joint

SPINE PROCEDURES

Epidural Steroid Injection

- ☐Interlaminar
- ☐Transforaminal/Selective Nerve Root
- ☐Facet Injection

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

JOINT ASPIRATION

*Select labs needed

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

☐LEFT ☐RIGHT

- ☐Wrist*
- ☐Elbow*
- ☐Hip*
- ☐Shoulder*
- ☐Ankle*

ULTRASOUND ASPIRATION

- ☐Knee* ☐R ☐L
- ☐Baker's Cyst ☐R ☐L

ULTRASOUND INJECTIONS

- ☐SC Joint ☐R ☐L
- ☐Saphenous Nerve ☐R ☐L
- ☐Lateral Cutaneous Nerve ☐R ☐L
- ☐Popliteal Nerve ☐R ☐L

CT INJECTIONS

- ☐Periformis ☐R ☐L
- ☐Iliopsoas ☐R ☐L
- ☐Botox ☐R ☐L

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)

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