The Miriam Hospital
A Lifespan Partner

Interventional Radiology
Consult / Procedure Request Form

US Phone: **401-793-4440** Fax: **401-793-4441**
CT Phone: **401-793-4437** Fax: **401-793-4431**
VIR Phone: **401-793-4429** Fax: **401-793-7203**
Ablation Services :
Phone **: 401-793-4429** Fax **: 401-793-7203**

Date of Request:__________

Patient Name:____**MR#**________________________

DOB:___/____/_____ SEX: M F Patient Home/Cell #:____

Patient Location: InPt : Room #_____________OutPt : Address____

Insurance/Primary: ____________________________Policy #: _________________________ Subscriber: ___________________

Requesting Physician/LIP (**Print/Signature**): ____(**Title**)

Backline #:_________________________________MD Page #____

Consult/Procedure Requested:____

Final procedure to be determined by the Interventionalist

Brief History/Indication:____

Special instructions/Desired Lab Tests on Sample:____

Can patient give Consent? ☐ Yes ☐ No If not, who will give consent:_____________________________________
Contact #:______________________________________

Is the patient NPO? ☐ Yes ☐ No

Interpreter needed? ☐ Yes ☐ No If Yes: Preferred Written/Oral language:______________________

Diagnostic Exam From? ☐ Lifespan ☐ Outside____

Is patient taking any Anticoagulants/Antiplatelets? ☐ Yes ☐ No If Yes Please List:________________________________

Allergies: ☐ NKDA ☐ Yes List:____

Lab Work:
Date drawn:________/___/________ Where?______________________

PT_________PTT____________INR____________PLATELETS___________CREAT______________

Below is for Radiology use only

Intended Procedure and/or Comments:____

____

IR Approving Procedure (**Print/Sign**):____**Today's Date:** ________ **Time:** ___AM/PM

Scheduled: **Date:**______/__________/______ **Time:**________________