Interventional Radiology

KootenaiHealth

PATIENT INFORMATION

Patient Name:_____DOB:_____

Phone#:_____

Parent name (if patient is a minor):_____

Please specify ICD-10 and narrative diagnosis:
(Do not use unspecified, rule out, probable, possible, suspected or routine)

REFERRING PROVIDER

Date:_____

Ordering Provider (PRINT):_____

Ordering Providers Signature:_____

CC Provider: _____

Phone: _____

☐ STAT: Immediate Fax_____

Provider number to contact for critical results:

_____

Sedation or Anesthesia Requires H&P dated within the past 30 days

CT
(or US per Radiologist discretion)

- ☐ Calcium Scoring
- ☐ Coronary Arteries
  - ☐ w/ Calcium Scoring
  - ☐ w/o Calcium Scoring
- ☐ Therapy Planning
- ☐ Heart Structures & Morphology
- ☐ Biopsy w/ Sedation
  Location: _____
- ☐ Aspiration
  Location: _____
- ☐ Percutaneous Abscess Drain:
  Location: _____
- ☐ Nephrostomy
- ☐ Chest Tube Insertion
- ☐ TAVR
- ☐ Cystogram Contrast
- ☐ Angio Chest (Gated)

Ultrasound
(or CT per Radiologist discretion)

- ☐ Liver Biopsy w/ Sedation
  - ☐ w/ Abdomen Complete
- ☐ Renal Biopsy w/ Sedation
- ☐ Other Biopsy w/ Sedation
  Location:_____
- ☐ Pseudoaneurysm Repair (Thrombin Injection)
- ☐ Abscess Drain Guidance
  Location:_____

X-Ray

- ☐ **G/J Tube** Exchange / Check / Removal
- ☐ **G-Tube** Exchange / Check / Removal
- ☐ **NG Tube** Exchange / Check / Removal
- ☐ **J-Tube** Exchange / Check / Removal
- ☐ **Myelogram w/ Sedation**
  Cervical / Thoracic / Lumbar
- ☐ Epidural Steroid Injection - Lumbar Midline Only
  Level: _____
- ☐ Lumbar Puncture
  Complete the Body Fluid Test Request
- ☐ Blood Patch
- ☐ Intrathecal Chemotherapy
- ☐ Modified Barium Swallow
- ☐ Pediatric Modified Barium Swallow
  (Call McGrane Center at 208-625-5356)

Interventional Radiology

Port Insertion / Removal
- ☐ Chest ☐ ☐
- ☐ Arm ☐ ☐

PICC Lines
- ☐ Tunneled IJ ☐ ☐
- ☐ Non-Tunneled ☐

Catheters
- ☐ Tunneled ☐ ☐
- ☐ Non-Tunneled ☐ ☐
- ☐ Pleurex Catheter ☐ ☐

Nephrostomy Tube
- ☐ Insertion ☐ Removal ☐ Change
  ☐ Left ☐ Right

Biliary Drain
- ☐ Insertion ☐ Removal ☐ Change

Gastric Tube
- ☐ G - Tube Placement/Upsize
- ☐ G/J - Tube Placement/Upsize
- ☐ G to G/J Conversion

Other:
- ☐ Fistulagram
- ☐ Transjugular Liver Biopsy
- ☐ Foreign Body Removal

Comments: _____

_____

*Pre-Procedure Consultation with radiologist required for these procedures. Order for consultation includes any recommended pre/ post procedural imaging studies

- ☐ Y-90*
- ☐ Chemoembolization*
- ☐ TIPS Procedure*
- ☐ TIPS Revision*
- ☐ Uterine Fibroid Embolization*
- ☐ Vena Cava Filter (IVC) Placement
- ☐ Vena Cava Filter (IVC) Removal
- ☐ CT Guided Celiac Plexus Block
- ☐ Kyphoplasty/Vertebroplasty*
  Level: _____
- ☐ Cryoablation/Microwave Ablation*
  Location: _____
- ☐ Pluvicto
- ☐ Other: _____

Angio*
- ☐ Visceral Abdomen / Pelvis
- ☐ Carotid / Cerebral
- ☐ Renal Arteries
- ☐ Chest
- Extremity
  - ☐ Upper Left ☐ Upper Right
  - ☐ Lower Left ☐ Lower Right
- Visceral
  - ☐ Aorta ☐ Pulmonary

Venography*
- Extremity
  - ☐ Upper Left ☐ Upper Right
  - ☐ Lower Left ☐ Lower Right

PLACE PATIENT STICKER HERE

KootenaiHealth

To schedule please call | T: 208-625-6360 | F: 208-625-6361 | M-F 7am-5pm

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Referral Attachment