



# INTERVENTIONAL RADIOLOGY REQUISITION FORM

Patient Stamp/Plate

**Patient Demographics**  
**Date:** \_\_\_\_\_ **BV History #:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Insurance:** \_\_\_\_\_ **Pre-authorization #:** \_\_\_\_\_  
**Reason for Exam:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

**Requesting Physician Information:**  
**Requestor Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
**Pager #** \_\_\_\_\_ **Office #** \_\_\_\_\_ **Fax #** \_\_\_\_\_

**Blood work**  
**PT** \_\_\_\_\_ **PTT** \_\_\_\_\_ **BUN** \_\_\_\_\_ **Creatinine** \_\_\_\_\_  
**CBC** \_\_\_\_\_ **Heme-8** \_\_\_\_\_

**Angio/Neuro**

- Carotids
- Vertebrales

**Interventional** (Please Specify): \_\_\_\_\_

**Angio/Body**

Upper Extremity (Please Specify): \_\_\_\_\_

- Pulmonary
- Abdominal
- Pelvis
- Lower Extremity \_\_\_\_\_

- IVC Filter
- Transluminal Balloon Angioplasty
- Transcatheter introduction w/ intravascular stents
- Transcatheter therapy embolization
- Transcatheter infusion (thrombolysis)

**Visceral** (Please Specify): \_\_\_\_\_

- Splenic
- Hepatic
- Renals
- Transjugular liver biopsy

**Percutaneous tube drainage**

- Placement
- Change
- Removal

**Perma-Cath** (Please Specify): \_\_\_\_\_

- Arteriovenous Shunt (AV Fistula)

**Other**, (Please Specify): \_\_\_\_\_

**PLEASE FAX TO 410-550-8188 WITH BLOODWORK AND INSURANCE INFORMATION AND FOR SPECIFIC INSTRUCTIONS FOR YOUR PATIENT.**