Patient Identification	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298
Name : **MR#:** **Date:** **Phone #:**	**RADIOLOGY ORDER** **VASCULAR INTERVENTIONAL PROCEDURES**

Fax to 804-828-7926, BVI 828-5544 Phone: 804-827-2329, BVI 828-2600

If you have questions about ordering or need a procedure not on this list, please call 804-628-1115, or pager 2599

Requesting ATTENDING physician/Clinical Service: _____

Contact Nurse Practitioner/Registered Nurse for questions (Phone/Pager #): _____

Diagnosis/Indication: _____ ICD-9 Code (required): _____

Does this patient require Anesthesia Services? □ Yes □ No

The following lab results needed with 30 days of procedure: **Blood Urea Nitrogen, Creatinine, Platelets, Prothrombin Time, Partial Thromboplastin Time/International Normalized Ratio.**

Legend:

R = Right
L = Left
B = Bilateral
UE = Upper Extremity
LE = Lower Extremity
PICC = Peripherally Inserted Central Catheter
SL = Single Lumen
DL = Double Lumen
TL = Triple Lumen (PICC only)

Procedures: Check box and circle side and location as appropriate. (Refer to legend above)

- □ Arteriogram R or L or B UE or LE
  - □ With Embolization or Other _____
  - □ With Intervention or Other _____
- □ Arterio Venous Fistula Declot R or L or B UE or LE
- □ Arterio Venous Fistulogram R or L or B UE or LE
- □ Biliary Catheter Check/Change
- □ CT Guided Plexus Block Celiac or Hypogastric
- □ Dialysis/Apheresis Catheter Placement Tunneled or Non Tunneled
- □ Drug Eluting Bead Embolization R or L
- □ Endovenous Thermal Ablation R or L
- □ Gastrostomy Change
- □ Gastrostomy Placement
- □ Gastrojejunostomy Tube Change
- □ Gastrojejunostomy Tube Placement
- □ Hickman Placement Yes / No SL or DL
- □ Inferior Vena Cava Filter Placement
- □ Inferior Vena Cava Filter Retrieval

□ Follow Up Visit:_____

Consult:

- □ Endovenous Thermal Ablation R or 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 or L
  - Kidney R or L
  - Lung R or L
- □ Therasphere R or L
- □ Other _____

- □ Percutaneous Nephrostomy/ NephroUreteral Stent Placement R or L or B
- □ Percutaneous Nephrostomy/ NephroUreteral Checked or Changed R or L or B
- □ Percutaneous Transhepatic Cholangiogram with Drainage
- □ PICC Change SL or DL or TL
- □ PICC Placement SL or DL or TL
- □ Portacath Placement SL or DL
  Power or Vortex
- □ Portacath Removal
- □ Powerline Placement SL or DL
- □ Therasphere Infusion R or L
- □ Transjugular Intraheptic Portosystemic Shunt or TIPS Follow UP
- □ Transvascular biopsy with Pressures Liver Kidney
- □ Tunneled Catheter Removal
- □ Venogram R or L or B UE or LE or Other:_____
- □ Other: _____

Physician Printed Name & Signature:

(Note: Federal regulations require a physician's signature)

Physician Signature _____

Physician Printed Name _____

Physician Pager _____ Date _____

****Provider Signature is required for Radiology Order**