McLaren
GREATERLANSING

INTERVENTIONAL RADIOLOGY REQUEST/HISTORY&PHYSICAL

Referring Physician/office staff to complete:

Patient Name: _____ D.O.B._____

Patient Phone Number: _____ Cell Phone: _____

Insurance:_____ Pre Auth #:_____

PCP Name:_____ History of Kidney Disease? Yes No / History of Tobacco Use? Yes No

Requesting Physician Name: _____ Phone Number:_____

Prior Imaging Studies: _____ Where: _____

Allergies: _____ Latex allergy? Yes No Contrast Allergy? Yes No

Meds (may attach list): _____ Interpreter Needed: Yes No

PT/PTT done in past 7 days? Yes No Is patient on anticoagulation/antiplatelet ? yes no if yes name of medication_____

Referring Physician to Complete:

Procedure Requested: _____ Reason for Procedure:_____

Brief History: _____

Mental Status_____ Social History_____

Pertinent past medical/surgical History: _____

Vitals: temp_____ pulse_____ resp_____ BP_____/_____

Pertinent Review of Systems: _____

Physical Exam: Heart: Normal Abnormal _____

Lungs: Normal Abnormal: _____

Abdomen:_____

Other: _____

Assessment and Plan: _____

Referring Physician Signature: _____ Date: _____

Radiologist to Complete: (please circle)

Modality to use: Ultrasound CT Scan Special Procedures

Cytology Tech needed: Yes No

Patient Position: Supine Prone Oblique

Contrast Type Oral IV

COMMENTS: _____

Refer to slice numbers from previous Imaging: _____

Choose one: Formalin B5-Fix Flow Cytometry Slides Culture

Estimated Time for Procedure: 30 mins 60 min. 90 mins 2 HRS. Other:

Lab work necessary? Yes No If yes: PTT INR BUN Creatinine CBC Other:

Other Information/Instructions: _____

Radiologist Completing worksheet: _____ Date: _____

Appt. Date:_____ Time:_____ Patient Arrival Time:_____

RN office phone: 517-975-7727 **RN office fax: 517-975-8804** Groupwise_____ Paragon_____

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