TMH Department of Diagnostic Imaging 01-07
CT/US Imaging Interventional Procedure Order Sheet

Phone: 401-793-4429
Fax: 401-793-7203

Patient Name:_____ DOB:____/____/____

Patient Location:_____Patient Home/Cell #:_____

Ordering Physician:_____MD Page/Back line #:_____

Ordering Physician or Rad Signature: _____ PCP_____

Brief History:_____

_____

Procedure Requested:_____

☐ US Guidance ☐ CT Guidance ☐ Fluoro Guidance

Special Instructions: _____

Lab test desired on sample: ☐ Pathology ☐ Cytology ☐ Microbiology

Can patient give Consent? ☐ Yes ☐ No If not, who will give consent? _____Contact #:_____

Interpreter necessary? ☐ Yes ☐ No Language:_____

Diagnostic Exam From? ☐TMH ☐RIH (fax report) ☐RIMI (fax report) ☐Outside (fax report):_____

Is patient taking any of the following-if so hold medication as follows: Aspirin – 2 days; NSAIDS – 2 days; Plavix – 10 days
Sub Q Heparin – 12 hours IV Heparin – 4 hours Coumadin, Lovenox, Avixtra – call 793-4429 for instructions
If yes, who will tell patient to stop?_____ When? _____ Hx liver dysfunction/coagulopathy? ☐

Allergies (including Latex):_____ Insulin Dependant Diabetic: ☐ Yes ☐ No

Lab Work:
☐ Not necessary ☐ Done Date drawn:____/____/_____ Where?_____☐ Referring Physician to do

PT/PTT: ___/____ INR: _____ PLATELETS:_____ H/H: _____/_____ Type & Cross: _____ PFA-100____

Patient Position for Procedure: ☐ Supine ☐ Prone ☐ Decubitus Side of Lesion: ☐Right ☐Left

Patient Address:_____ City/Sate/Zip:_____

Insurance/Primary: _____Policy #: _____ Subscriber: _____

Insurance/Primary: _____Policy #: _____ Subscriber: _____

Attending/PA Approving Procedure:_____Today's Date:____/_____/_____

Scheduled: Date:_____/_____/_____ Time:_____