Rhode Island Hospital
Interventional Radiology
Consult / Procedure Request Form

US Phone: **401-444-5309** Fax: **401-444-7729**
CT Phone: **401-444-8293** Fax: **401-444-7729**
VIR Phone: **401-444-5194** Fax: **401-444-8756**
Ablation Services :
Phone :**401- 444-5707** Fax **401-444-7729**

Date of Request:__________

Patient Name:____**MR#**______________________

DOB:___/____/_____ **SEX**: **M F** **Patient Home/Cell #:**______________________________________

Patient Location: InPt : Room #____________**OutPt : Address**_______________________________________

Insurance/Primary: __________________________**Policy #:** ________________________ **Subscriber:** ______________

Requesting Physician/LIP (Print/Signature): ____(**Title**)

Backline #:___________**MD Page #**_________

Consult/Procedure Requested:____

Final procedure to be determined by the Interventionalist

Brief History/Indication:____

____

Special instructions/Desired Lab Tests on Sample:____

Can patient give Consent? ☐ **Yes** ☐ **No** **If not, who will give consent:**__________________________________
Contact #:__________________________________

Is the patient NPO? ☐ **Yes** ☐ **No**

Interpreter needed? ☐ **Yes** ☐ **No** **If Yes: Preferred Written/Oral language:**___________________

Diagnostic Exam From? ☐ **Lifespan** ☐ **Outside**__________________________________

Is patient taking any Anticoagulants/Antiplatelets? ☐ **Yes** ☐ **No** **If Yes Please List:**__________________________

Allergies: ☐ **NKDA** ☐ **Yes** **List:**____

Lab Work: Date drawn:_______/____/_______ Where?_____________________

PT________**PTT**___________**INR**___________**PLATELETS**__________**CREAT**__________________

Below is for Radiology use only*

Intended Procedure and/or Comments:____

____

Admitting Service:____

IR Approving Procedure (Print/Sign):___________________________________**Today's Date:**_________**Time:** ________**AM/PM**

Scheduled: **Date:_______/___________/_______** **Time:__________________**