



Medical Record Number: _____
 Patient Name: _____
 Address: _____
 Phone number (c/h/w): _____
 Date of Birth: _____ Sex: Female Male
 Height: _____ Weight: _____
 Insurance Plan: _____
 FSC #: _____ Insur Member #: _____

Required information to schedule
 Attending MD Name (Print): _____
 NPI #: _____ Office Phone #: _____
 Fax: _____ PIC: _____
 Office Contact Person: _____
 Phone #: _____

ICD Codes: _____
 Diagnosis/Indications: _____

Urgency: Stat Routine*
Location (circle): Emory University Hospital, Emory University Midtown Hospital, Emory St. Joseph's Hospital, Emory Decatur Hospital, Emory Hillandale Hospital, Winship Emory Hospital
For Biopsies and Abscess drains, please ensure that there is supported imaging (PET, MRI, or CT) completed within the last three months sent over. Thyroid biopsies require a thyroid ultrasound completed within the last 12 months. Laterality and dimensions of nodule for FNA are required for thyroid orders. Please ensure that there is recent clinical note and imaging report sent over.

<p><input type="checkbox"/> Biopsy: (Modality Type: <input type="checkbox"/> CT <input type="checkbox"/> US) <input type="checkbox"/> Tissue Exam <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Kidney (Medical/Targeted) <input type="checkbox"/> Peritoneal <input type="checkbox"/> Lymph Node <input type="checkbox"/> Abdominal <input type="checkbox"/> Bone <input type="checkbox"/> Thyroid <input type="checkbox"/> Lung (L or R) <input type="checkbox"/> Liver (Medical/Targeted) <input type="checkbox"/> Other _____ _____</p> <p><input type="checkbox"/> Drains: (Modality Types <input type="checkbox"/> CT <input type="checkbox"/> US or <input type="checkbox"/> IR) <input type="checkbox"/> US Paracentesis (Therapeutic/Diagnostic) <input type="checkbox"/> US Thoracentesis (Therapeutic/Diagnostic) <input type="checkbox"/> Abscesses (Modality Types <input type="checkbox"/> CT <input type="checkbox"/> US or <input type="checkbox"/> IR) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Suprapubic Catheter <input type="checkbox"/> IR Nephrostomy <input type="checkbox"/> IR Biliary <input type="checkbox"/> Cholecystostomy <input type="checkbox"/> Gtube <input type="checkbox"/> Jtube <input type="checkbox"/> GJtube Options: <input type="checkbox"/> New Placement <input type="checkbox"/> Removal <input type="checkbox"/> Exchange <input type="checkbox"/> Evaluation/Manipulation <i>New Jtube placements require a surgery consult, not completed in IR</i></p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Vascular Access: <input type="checkbox"/> Port <input type="checkbox"/> Arm PICC <input type="checkbox"/> Non-Tunneled Central Line <input type="checkbox"/> Tunneled Central Line <input type="checkbox"/> Lumens: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Options: <input type="checkbox"/> New Placement <input type="checkbox"/> Removal <input type="checkbox"/> Exchange <input type="checkbox"/> Evaluation/Manipulation <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Ambulatory Referrals (Procedures that require IR clinic visits) Specify: _____ <input type="checkbox"/> Uterine Fibroid Embolization <input type="checkbox"/> Liver Ablation <input type="checkbox"/> Kidney Ablation <input type="checkbox"/> Nerve Ablation <input type="checkbox"/> Foreign body removal (Nexplanon, etc.) <input type="checkbox"/> Adrenal Vein Sampling <input type="checkbox"/> Nerve Block <input type="checkbox"/> IVC Filter placement <input type="checkbox"/> IVC removal <input type="checkbox"/> Prostate Artery Embolization <input type="checkbox"/> Ovarian Vein Embolization <input type="checkbox"/> Pelvic Venogram <input type="checkbox"/> Pulmonary Embolization <input type="checkbox"/> Biliary Endoscopy (Spy glass) <input type="checkbox"/> Thoracic Duct Embolization <input type="checkbox"/> TIPSS <input type="checkbox"/> Venous Malformation Embolization <input type="checkbox"/> Pleurx Drain Placement <input type="checkbox"/> Other: _____ _____ _____ _____ _____</p>
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Physician Signature: _____ (MD, DO, NP, PA) **Date:** _____ **Time:** _____