

**UNIVERSITY OF VIRGINIA HEALTH SYSTEM
DEPARTMENT OF RADIOLOGY
ANGIO/INTERVENTIONAL IMAGING REQUEST FORM**

Please Fax to (434) 982-0887
Schedule at (434) 924-9401

PLACE LABEL HERE

Ordering Date _____

SS# _____

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Patient Name: _____ MR# _____ Date of Test _____

DOB ____/____/____ Weight: _____ Phone # _____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #
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Referring Clinic/Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number
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STUDY DESIRED (Circle Side if appropriate)

X	Arterial Study	X	Venous Study	X	Liver Study	X	Kidney Study
	Upper Extrem Arteriogram		IVC Filter Placement		Biliary Tube Check		Nephrostomy Tube check
	Thoracic Arteriogram		PICC Placement		TIPS Procedure		Perc. Nephrostomy Lt Rt
	Pulmonary Arteriogram		Tunneled Central Line Place		Transjugular Liver Biopsy		Perc. Litho
	Aortogram w/runoff		Upper Ext Veno Lt Rt		Perc Transhepatic Chole		Suprapubic Tube Check
	Mesenteric Arteriogram		Lower Ext Veno Lt Rt		RF Ablation Liver		
	Abdominal Arteriogram		Fistulagram				
	Bilat Renal Arteriogram		Central Venous line check				
			Port				

Other Study-Not Listed (Specify):

Clinical Indications for Exam (Mandatory):

Relevant Signs/Symptoms Diagnosis if not listed below (MANDATORY—MUST be ICD-9 Numeric Code):

(A list of most common ICD-9 codes is available on the back as a reference only)

Please have patient bring any pertinent prior outside films.

Are there any special considerations for pts safety? (e.g. non-english speaking, sz disorder, pregnancy, M.R., medications that could affect pt. Testing) Explain: _____

Does the Patient have any allergies? Yes No If Yes, please explain: _____

Physician Signature: _____



Updated 9-04

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