HRH | HUDSON REGIONAL HOSPITAL

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INTERVENTIONAL RADIOLOGY REFERRAL

☐ Kevin Herman, MD ☐ David Soto, MD

☐ Vincent Gallo, MD ☐ John Rundback, MD

TODAYS DATE:

ALLERGIES:

PATIENTS NAME: _____

MR#: _____

DATE OF BIRTH:

PHONE:

PERFORMING PHYSICIAN:

REFERRAL: ☐ CONSULTATION ☐ PROCEDURE

DESIRED PROCEDURE DATE/TIME:

REASON/DIAGNOSIS:

ICD-10 CODE

INSURANCE:

ANESTHESIA: ☐ YES ☐ NO

ONCOLOGY INTERVENTION

☐ Chemotherapy Port Insertion
- ☐ Single Lumen
- ☐ Double Lumen
- ☐ Arm Port
- ☐ Port Removal

☐ Tunneled Catheter

☐ PICC Line
- ☐ Single Lumen
- ☐ Double Lumen
- ☐ Triple Lumen

☐ IVC Filter Placement

☐ IVC Filter Removal

☐ IVC Stenting

☐ Radiofrequency Ablation
Site_____

☐ Chemoembolization

☐ Y-90 Hepatic Radioembolization
- ☐ Sirsphere Part I
- ☐ Sirsphere Part II

☐ Biopsy ☐ CT ☐ US
Site_____

☐ Paracentesis

☐ Thoracentesis

☐ Aspira Catheter Placement
- ☐ Chest
- ☐ Abdomen

☐ Other_____

☐ Aspira Catheter Removal
- ☐ Chest
- ☐ Abdomen

☐ Chest Tube Insertion

REPRODUCTIVE INTERVENTION

☐ Uterine Fibroid Embolization (UFE)

☐ Pelvic Venous Congestion

☐ Fallopian Tube Recanalization

☐ Varicocele

☐ Other_____

NONVASCULAR INTERVENTION

☐ Kyphoplasty
Level (s)_____

☐ Drainage
Site_____

☐ Nephrostomy Tube Placement Initial
☐ Right ☐ Left

☐ Nephrostomy Tube Removal
☐ Right ☐ Left

☐ Nephrostomy Tube Exchange
☐ Right ☐ Left

☐ Nephrostogram
☐ Right ☐ Left

☐ Ureteral Stent Placement

☐ Ureteral Stent Exchange

☐ Biliary Tube Placement

☐ Biliary Tube Check

☐ Biliary Tube Exchange

☐ Biliary Stent Placement

☐ Percutaneous Gastrostomy Tube
☐ Placement ☐ Exchange

☐ Percutaneous Gastrojejunostomy Tube
☐ Placement ☐ Exchange

☐ Other_____

DIALYSIS INTERVENTION

☐ Fistulagram/Graftogram
Reason_____

☐ Temporary Catheter
☐ Placement ☐ Removal

☐ Perm Catheter
☐ Placement ☐ Removal

ARTERIAL/VENOUS PROCEDURES

ARTERIAL DIAGNOSTIC

☐ Carotid

☐ Cerebral

☐ Upper Extremity

☐ Lower Extremity

☐ Renal

☐ Viceral/Mesenteric

☐ Other_____

ARTERIAL INTERVENTION

☐ Carotid

☐ Upper Extremity

☐ Lower Extremity

☐ Pulmonary

☐ Renal

☐ Viceral/Mesenteric

☐ AAA

☐ Thrombolysis

☐ Thoracic Aortic Aneurysm

☐ Other_____

VENOUS DIAGNOSTIC

☐ Upper Extremity (Non Dialysis)

☐ Lower Extremity (Non Dialysis)

VENOUS INTERVENTION

☐ Laser Varicose Vein Ablation

☐ Ambulatory Microphiebotomy

☐ US Guided Sclerotherapy

☐ Spider Vein Therapy

☐ DVT

☐ Upper Extremity

☐ Lower Extremity

☐ TIPS

REF MD: _____ PMD/CARD: _____

OTHER PROCEDURES: _____

SPECIAL EQUIPMENT NEEDED: _____

Physician's Signature:_____ Date: _____ Time: _____