Date Hospital Received: _____

Consult Date: _____

Consult Time: _____

Ordering Physician: _____

MEDFORD RADIOLOGY GROUP

IR Consult Scheduling Request Form

Date MRG Received: _____

Diagnosis Code: _____

CPT Codes: _____

_____

Patient Name: _____ DOB: _____

Symptoms/Diagnosis: _____

Current medications, current treatment and/or special considerations for the patient:

_____

_____

_____

IR Requested Procedure: _____

Type of Exam: ☐ Ablation ☐ Biopsy ☐ Drainage ☐ Tube/stent placement ☐ Embolization ☐ Y-90 ☐ Vertebroplasty

To be performed in: ☐ CT ☐ Cath Lab ☐ Ultrasound ☐ Fluoro

Sedation: ☐ IV/Conscious ☐ General Anesthesia ☐ Local ☐ None

Additional Equipment needed: Cryo (Please select vendor): ☐ Galil ☐ Waveform ☐ Microwave (Neuwave) ☐ Radiofrequency (Neuwave)

ADDITIONAL INFORMATION: _____

_____

_____

Signature: _____ Date: _____

☐ Bose, Brent MD ☐ Heeter, Zachary MD ☐ Palmer, Eric MD ☐ Hardy, Hal MD ☐ Thompson, Joe MD

PROCEDURE SCHEDULED: (FACILITY) _____ (DATE) _____

Primary Insurance: _____ Authorization # _____ Date: _____

Secondary Insurance: _____ Authorization # _____ Date: _____