

Today's Date: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_

## Radiology Consult Form for Interventional Procedures

Patient's Name: \_\_\_\_\_ MRN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Floor #: \_\_\_\_\_ Floor Location:  East Newton  Menino Pavilion  
 MD Phone/Pager: \_\_\_\_\_ Procedure Requested: \_\_\_\_\_

**Clinical Information** (Please be as detailed as possible):

• **The Patient must have History & Physical within 30 days prior to procedure. Please fax this to (617)-414-1698.**

Can patient give consent?  Yes  No

If no, please give the name of person who will consent for the patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does the patient speak English?  Yes  No If No, what language? \_\_\_\_\_

Does patient have doctor's orders?  Yes  No If no, a MD order is needed prior to scheduling the procedure.

Does the patient have **Sleep Apnea**?  Yes  No If yes, an anesthesia consult is needed.

Does the patient take **Metformin, Glucophage®, Glucophage XR®, Metaglip®, Avandamet®, Fortamet®, Glumetza®, Riomet®, Gluovance®, Actoplus MET®, or Janumet®**?  Yes  No

Is the patient an inpatient?  Yes  No

If the patient is an outpatient, you will need to call the **Medical Short Stay Unit** at (617)-638-6350

**Screening Questions:**

<b>Aspirin</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IDDM</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pregnancy Status</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Coumadin</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>HTN</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IV</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Heparin</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hx of Renal Failure</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DNR Status</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>LMWH</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Contrast Allergy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pacemaker/ICD</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Plavix</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Drug/Food Allergy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>NSAIDS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**Labs\*: Must be within 30 days of the procedure**

Date _____	Platelets _____
Date _____	PT/PTT/INR ____ / ____ / ____
Date _____	BUN/Cr ____ / ____ / ____
Date _____	WBC _____
Date _____	PSA** _____

\* No Lab work required for Sonohysterograms.

\*\* PSA required prior to all Prostate Biopsies

This form must be completed in its entirety before we will schedule the Radiology procedure. Please fax completed form to (617) 414-1698. Once the completed form is received by our coordinator, you (referring provider) will be contacted with a scheduled date, time and specific instructions for the radiology interventional procedure.

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Consulting Physician: \_\_\_\_\_ Date: \_\_\_\_\_