



Boston University School of Medicine

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

Request procedure Date: \_\_\_\_\_

## Interventional Neuroradiology Consult Form

Patient's Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Floor Location: \_\_\_\_\_ East Newton \_\_\_\_ Menino \_\_\_\_

Procedure Requested: \_\_\_\_\_

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

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

Can patient consent? Yes \_\_\_ No \_\_\_ If no, family member name & contact #: \_\_\_\_\_

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

Does the patient take **Metformin, Glucophage®**? Yes \_\_\_ No \_\_\_

Does the patient have **Allergies**? \_\_\_\_\_

Is the patient an inpatient? Yes \_\_\_ No \_\_\_

### **Screening Questions:**

**Diabetes** Yes \_\_\_ No \_\_\_ **Pregnant** Yes \_\_\_ No \_\_\_

**Coumadin** Yes \_\_\_ No \_\_\_ **Hx Renal Failure** Yes \_\_\_ No \_\_\_ **DNR Status** Yes \_\_\_ No \_\_\_

**Heparin** Yes \_\_\_ No \_\_\_

**Labs\*: Must be within 90 days of the procedure (or 30 days if history of diabetes, renal insufficiency)**

Date \_\_\_\_\_ Platelets \_\_\_\_\_

Date \_\_\_\_\_ PT/PTT/INR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date \_\_\_\_\_ Creatinine \_\_\_\_\_

This form must be completed and faxed before we schedule the procedure.

**Please fax to (617) 414-1698.**

Completed by: \_\_\_\_\_ Pager: \_\_\_\_\_