Name : MR#: DOB: Phone #: (Patient Identification)	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Non-Vascular Interventional Radiology Procedure Request/Order**

Phone: 804-827-4787 **Fax: 804-828-5570** **Virtual Pager: 9128**

Requesting ATTENDING Provider/Clinical Service: ____

Contact Nurse Practitioner/Registered Nurse for questions (Phone/Pager #): ______________________________

Diagnosis/Indication: ____ ICD-9 Code (required): _________

The following lab results needed within 30 days of procedure: Blood Urea Nitrogen, Creatinine, Platelets, Prothrombin Time, Partial Thromboplastin Time / International Normalized Ratio

Lab results are REQUIRED prior to the scheduling appointments – if outside facility, please attach results

Procedure type:

□ **Biopsy** □ **Drainage/Aspiration** □ **Aspira Catheter** □ **Radiofrequency Ablation**

□ **Other**: ________________________________

Specific location of procedure/study ***(check all applicable):*** __________________________

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CT/ Ultrasound Guided Procedure:	**Fluoro-Guided Procedure:**
□ Bone/Soft Tissue □ Abscess Drainage □ Paracentesis □ Liver □ Thoracentesis □ Lung □ Pancreas □ Thyroid □ Other ________________________________	□ Cervical Myelogram □ Lumbar Myelogram □ Thoracic Myelogram □ Lumbar Puncture □ Other __________________________

MR-Guided Procedure:	**Provider Printed Name & Signature:** (Note: Federal regulations require a provider's signature)
□ Cardiac □ Prostate □ Other __________________________ Breast: Call to schedule : 237-6666	Provider Signature ______________________________ Provider Printed Name _________________________ Provider Pager __________ Date ________________ Office/Location Code ________________________