

Department of Radiology

**Abdominal Interventional Procedures
Request Form**

Phone: 617-726-8396 (Adult) 617-724-4207 (Pedi)

PATIENT INFORMATION

Name: _____

MGH Unit #: _____ DOB: _____

Patient Location (Check One):

Inpatient Floor _____ Ext _____

Outpatient

PROCEDURE REQUESTED: _____

Right Left N/A

HISTORY: _____

DIABETIC? Yes No

AIRWAY PROBLEM? Yes No

ANTICOAGULATION

Anticoagulant? Yes No

Specify anticoagulant: _____

If Yes, stopped when? _____

Coumadin? Yes No

Heparin/LMWH? Yes No

Plavix? Yes No

INR _____ PTT _____ Platelets _____

CONSENT: From Patient

From Other Name: _____

Relationship: _____ Phone: _____

LANGUAGE: English Other: _____

IMAGING

MGH Imaging Outside Imaging

****NEED TO SEE IMAGING BEFORE SCHEDULING****

FOR FLUID ASPIRATION (THORA or PARA)

Therapeutic Large Volume Aspiration OR

Fluid for Diagnostic Purposes Only

Are specimens to be sent? Yes No

Microbiology Cytology Cell Count

Other (Specify) _____

**PLEASE COMPLETE AND FAX TO:
617-726-4891 (Adult) 617-726-8360 (PEDI)**

PHYSICIAN INFORMATION

Requesting Attending: _____

Phone # _____ BEEPER # _____

Fellow/Resident: _____

Phone # _____ BEEPER # _____

Intern: _____

Phone # _____ BEEPER # _____

Form Completed By (Please Print):

_____ DATE _____

**PLEASE COMPLETE ALL INFORMATION
INCOMPLETE FORMS WILL DELAY SCHEDULING**

FOR OFFICE USE ONLY

Radiologist Comments:

Procedure: _____

Location: CT US PR64

Sedation: None Nursing GA

Imaging: Modality _____ Date _____

Series # _____ Image # _____

Comments: _____

Radiologist Initials: _____

Date and Time of Appointment: