

VASCULAR RADIOLOGY FAX



Please review & complete this form & fax back to Amy or Karen @ X68476. This is a confirmation of previously phone - scheduled appointment.
QUESTIONS? PLEASE CALL X68314

TO:
FAX:
PHONE:

APPOINTMENT DATE & TIME:

Check-in Ellison 2 Radiology
See other instructions below

Notice of Confidentiality

This fax transmission may contain confidential or privileged information. The utilization of its contents is intended for the addressee. Any other use, disclosure or dissemination, distribution or copying of this communication could violate privacy and is prohibited. If you are not the intended recipient or representative of the recipient, please contact/notify the sender at (617) 726-8314 or by fax at (617)726-8476 and destroy the contents.

PATIENT INFO:

Name _____

MRN: _____ DOB: _____

Home ph# (_____) _____

Insurance: _____

NOTE: Please get required referrals

Is pt able to consent? Y__N__

If not, who consents for patient? _____

*Please check here if pt needs an interpreter _____

Indicate language required _____

PROCEDURE & CLINICAL INFO:

PROCEDURE REQUESTED: _____

Body site: (indicate R/L and upper or lower) _____

DX _____

Clinical HX: _____

Attending MD: _____

Requesting MD _____ **BEEP:** _____

LABWORK: (not more than 30 days old)

Fax all outside labs to X68476 w/ Pt Name & DOS on fax

PT ____ **PTT** ____ **PLT** ____

K ____

Cr ____ **BUN** ____

COAGULATION ISSUES

Is the patient on blood thinners? _____ Date stopped _____

Please note that thinners usually must be discontinued several days prior to interventional procedures.

CHECK IF ONE APPLYS:

Coumadin__ Heparin__ Fragmin__ Plavix__ Argantroban__ Other _____

CLINICAL HX

Allergies _____

Precautions _____

Physical limitations/pain _____

NOTES/Instructions: