3333 Burnet Ave.
Cincinnati, Ohio 45229-3039

INTERVENTIONAL RADIOLOGY REFERRAL FORM

FAX form to 513-636-7794
STAT request call 513-636-8547

In addition to faxing this order, please call 513-636-8547

PATIENT INFORMATION

Patient's Name ______________________ CCHMC MR# ______________

Weight __________ KG Allergies ______________________

Patient Gender ____________ Date of Birth ____________ Home Phone ______________

Mother's Name ______________________

Parent/Guardian ______________________ Phone # (preferred) ______________

REASON FOR REFERRAL

History / Symptoms / Potential diagnosis / Special needs:

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SERVICES REQUESTED

- ☐ **Arthrogram**
  - ☐ Shoulder ☐ Hip ☐ Other ____________
- ☐ **Angiogram**
  - ☐ Cerebral ☐ Renal ☐ Other ____________
- ☐ **Bone Biopsy**
  - Site(s): ______________________
- ☐ **Botox Injections**
  - ☐ Submandibular: ☐ Right ☐ Left ☐ Bilateral
  - ☐ Parotid: ☐ Right ☐ Left ☐ Bilateral
- ☐ **Lumbar Puncture**
- ☐ **Biopsy**
  - Site(s): ______________________
- ☐ **Percutaneous Nephrostomy**
  - ☐ Right ☐ Left
- ☐ **Feeding Tubes –** ☐ **placement** ☐ **exchange**
  - ☐ G ☐ GJ ☐ NJ
- ☐ **Sclerotherapy**
  - Site(s): ______________________
- ☐ **Steroid Injection**
  - Joint(s): ______________________
  - ☐ Right ☐ Left ☐ Bilateral
- ☐ **Spine Intervention**
  - ☐ PARS ☐ Facet Level ____________
    - ☐ Right ☐ Left ☐ Bilateral
  - ☐ Other ______________________
- ☐ **Rheumatology steroid injection(s)**
  - See attached sheets
  - Total pages: ____ including referral form
- ☐ **Other Procedure:** ______________________

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REQUESTING PRACTITIONER / GROUP

Physician Name ______________________ Pager # ______________

Contact Person ______________________ Telephone ______________________

Office Address ______________________ Fax ______________________

____

Signature / Credentials of ordering Practitioner ______________________ Time: _____ Date: _____

Print Name ______________________