

NeuroInterventional Surgery Order Form

Scheduling Information

Call Patient to Schedule Patient Will Call to Schedule
Appointment Date _____
Appointment Time _____
Check-in Time _____
 Interpreter Needed—Language _____

Please schedule exam:

TRA Tacoma-on Cedar St. Anthony Hospital
 St. Clare Hospital St. Francis Hospital
 St. Joseph Medical Center Tacoma General Hospital
 Other _____

Patient Information

Patient Name _____
Date of Birth _____ SSN _____
Home Phone _____
Cell/Work Phone _____
Sex M F (Is patient pregnant? Y N)
Prior Exams: Date of Service _____
Facility Name/location _____

Insurance Information

Self Pay
Primary Insurance _____
(Copy and fax front and back of card)
Secondary Insurance _____
(Copy and fax front and back of card)
 Auto Collision L&I Injury Date _____
Claim # _____
Pre-Authorization # (if needed) _____

Exam/Procedure Requested

Area of Body _____
Diagnosis _____
IV Contrast Y N PRN
Previous Contrast Reaction? Y N
Contrast Allergy Y N

Screening Required for IV Contrast Studies

I authorize BUN/Creatinine test to be performed at the time of CT or MRI exam, if needed
Sedation for MRI required? Y N
If Yes, patient will need to arrive 30 minutes prior and have a driver.

CT Scan

Contrast as clinically indicated by radiologist, or no contrast
 Head Sinus Neck
 C-spine T-spine L-spine
 Chest Pelvis Abdomen
 Abdomen & Pelvis Other _____

CT Angiogram

Head & Neck Chest Coronary
 Abdomen Pelvis Abdomen & Pelvis
 Other _____

MRI

Contrast as clinically indicated by radiologist, or no contrast
 Brain C-spine L-spine T-spine
 MRA Head MRA Neck Other _____

NeuroInterventional Procedure

Cerebral Angiogram _____
 Coiling/Embolization
 with Anesthesia _____
 Stenting _____
 with Anesthesia _____
 Maxillary Embolization
 with Anesthesia _____

Referring Physician

Medical Provider Name _____ Medical Provider Signature _____
Date _____ *Provider Signature Required*