Order / Consult- Interventional Radiology

Fax ALL consults to 265-0067

Date: _____ Time: _____

Procedure Requested: _____

Diagnosis: _____

Reason for Procedure: _____

_____

_____

ALL FIELDS MUST BE COMPLETED BY PHYSICIAN

FAX consult and

- **Recent labs performed at non-Shands facility**
- **Current H&P if outpatient**

Fax: (352) 265-0067
Voice: (352) 265-0116

PATIENT INFORMATION

Date of Birth: _____ Patient weighs more than 300 lbs. ☐ Yes ☐ No

☐ Outpatient ☐ Inpatient Room #: _____ *(for inpatient consults)* ☐ Intubated ☐ Isolation - 2° to: _____

Allergies: ☐ NKDA ☐ Contrast ☐ Latex ☐ Other: _____

☐ Consentable
☐ Not Consentable — Name of Power of Attorney: _____
Relation to Patient: _____ Contact #: _____

ORDERING INFORMATION

Clinic / Service: _____

Contact Persons: _____ Phone #: _____ Fax # _____

Attending: _____ MD #: _____ Pager: _____

Ordered by: _____ MD #: _____ Pager: _____

Ordering Physician Signature: _____ MD #: _____

☐ ARNP ☐ Resident
☐ PA ☐ Fellow
☐ Intern ☐ Attending

FOR INTERVENTIONAL RADIOLOGY USE

Date: _____

PT:	Albumin:	AST:
PTT:	T. Bili:	ALT:
INR:	Alk Phos:	MELD:

Plan:

Approved by: _____ MD # _____ Scheduled by: _____

FOR INTERVENTIONAL RADIOLOGY USE

W

Shands at the University of Florida
Gainesville, Florida 32610

CO0001

Patient Name: Patient Identification #:

Order / Consult – Interventional Radiology *(page 1 of 1)*

Distribution: To be filed in order section of medical record

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