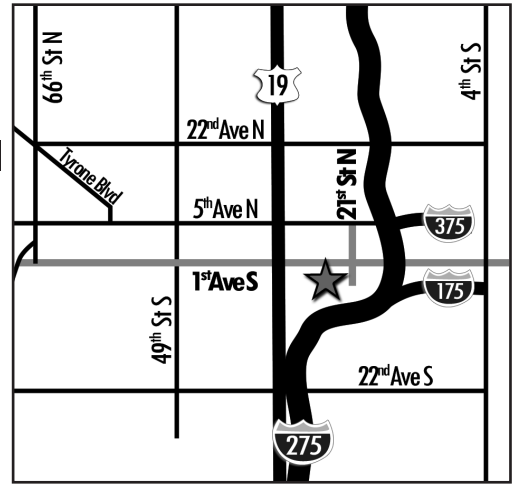


IR Clinic Department Only
Office: (727) 522-5800
Fax: (727) 233-0299



2100 1st Ave. South • St. Petersburg, FL 33712



Patient Name: _____

D.O.B.: ____/____/____

Pt. Cell #: (____) _____

Insurance: _____

Ordering Physician (print): _____

Physician Ph: (____) _____ Physician Fax: (____) _____

INTERVENTIONAL RADIOLOGY PROCEDURES

ANGIOGRAM / ARTERIOGRAM*

- CT Angio Abd/Pelvis Aorta w/ Runoff (75635/Q9967)
- Aortogram w/ Runoff
- Renal Angiogram ___Uni ___Bilat ___ w/Stent
- Mesenteric

PERIPHERAL VASCULAR PROCEDURES*

- ___L ___R ___ Bilat
- Laser Atherectomy
- Balloon Angioplasty
- Laser Atherectomy
- Stent Placement

VENOGRAM / VENOGRAPHY*

- Interior Vena Cavagram
- Superior Vena Cavagram
- Upper Extremity Venogram ___L ___R ___ Bilat
- Lower Extremity Venogram ___L ___R ___ Bilat
- Iliac Venography ___L ___R ___ Bilat

IVC FILTER PROCEDURES*

- IVC Filter Placement
- IVC Filter Removal

PORT / PICC PROCEDURES*

- Port Placement 36561, 76937, 36598, 77001
- Port Removal 36590, 36598, 76937, 77001
- Port Replacement 36590, 36561, 36598, 76937, 77001
- PICC Placement 36573, 76937, 71046, 77001
- PICC Replacement 76937, 77001, 71046
- Portogram 36598
- Port / PICC Flush 96523, 36593

DIALYSIS TREATMENT*

- Permanent Dialysis Catheter
___ Placement ___ Exchange ___ Removal
- Temporary Dialysis Catheter
___ Placement ___ Exchange ___ Removal

KYPHOPLASTY*

- Thoracic 22510, 22512, 22513, 22515
- Lumbar 22511, 22512, 22514, 22515

LASER VEIN TREATMENT

- Ultrasound Venous Insufficiency
___Uni 93971 ___L ___R ___ Bilat 93970
___ w/ ABI 93922
- Endovenous Laser Ablation, Phlebectomy
& Sclerotherapy as indicated
36478, 37766, 36471, 76942, 93971

MRI GUIDED BIOPSY**

- Breast 19085/19086

ULTRASOUND GUIDED BIOPSY**

- Breast Biopsy / Aspiration
19083, 19084 x2, 19000, 19001, 10005, 10006

Biopsy Required Moderate Sedation
99152, 99153 x3

Contact person for code add-ons:

Name: _____

Ext. _____

SEE REVERSE SIDE FOR TEST PREP (*, **) SCHEDULING INSTRUCTIONS AND FLUID TESTING REQUIREMENTS.

Physician Signature: _____
Date: _____

*** TEST PREP: ANGIO PROCEDURES**

- Patient Must be NPO 8 Hours Prior
- NO Blood Thinners / NO Aspirin / NO NSAIDS 5 days Prior to Procedure.
- Patient Must be Accompanied by a Driver.

**** TEST PREP: BIOPSY PROCEDURES**

- Patient Must be Accompanied by a Driver
- Patient Must be NPO 2 Hours Prior
- NO Blood Thinners / NO Aspirin / NO NSAIDS 5 days Prior to Procedure
- Pathology According to Insurance

Special Procedures Scheduling Process:

- Contact our IR Clinical Coordinator to schedule a patient consultation (522-5800).
- Fax Rx order with check-listed items below to expedite the scheduling request.
- Patient Consultation provides: Record Review, Prior Imaging Review, *Lab Draw, Procedure Scheduling with Prep Review, and Estimated Payment Overview.
- Prior Imaging & Reports performed at an outside facility **MUST** be provided prior to consultation **OR** no later than the scheduled consultation date.
- Referring physician office obtains Authorization 48 hours prior to procedure.

Referring Physician Required To Supply:

- Prescription Order with Clinical Diagnosis Codes
- Demos, Patient Medical History including Medications / Allergies
- Prior Imaging & Reports for Radiologist Review
- Labs: CBC, CMP and PT/INR *Drawn within 14 days of Procedure
- Insurance Authorization
- *Lab Order for Bloodwork
- *Diagnostic Fluid Testing Order for Paracentesis & Thoracentesis

IR CLINICAL COORDINATOR:

- Ph: (727) 522-5800 - Voice Mail
- Fax: (727) 233-0299
- 24-48 HR • BIZ HR

GATEWAY ANGIO-LAB:

2100 1st Ave S
St. Petersburg 33712