Request for Intervention Consult - Fluoroscopy

Referring MD: _____ Referring Clinic: _____

Patient Name: _____ DOB: _____

Reason for Referral: _____

Urgency: ☐ Routine (6-12 weeks) ☐ Semi – Urgent (2-4 weeks) ☐ URGENT (Within 2 weeks)

Procedure Requested: (Relevant imaging attached – within 3 years)
☐ **Spine Procedure** (Specify type of procedure):
_____

☐ **Cervical** (Specify side and level): _____
☐ **Thoracic** (Specify side and level): _____
☐ **Lumbar** (Specify side and level): _____

☐ **Joint Procedure** (Specify type of procedure): _____
☐ **Other Peripheral Procedure** (Specify type and Location):
_____

Procedure Details Discussed with Patient: Y/N _____

Patient Information:

Diagnosis:

Current Medications and Treatments:

Allergies (Select all that apply)	**Patient Details (Select all that apply)**	**Medication**
☐ Latex ☐ Contrast Dye ☐ Local Anesthetic ☐ Topical Antiseptic ☐ Corticosteroids ☐ Other: _____	☐ Pregnant ☐ Breastfeeding ☐ Glaucoma ☐ History of Diabetes ☐ History of Kidney Disease? Stage ___ ☐ Current Infection/Patient or Antibiotic ☐ History of Dialysis	☐ Anticoagulation **If patient is on Anticoagulant, please complete Spinal Procedures and Anticoagulants form on next page.** ☐ NSAIDS

Referring Physician: _____ **Billing #: _____**

Signature: _____ **Date: _____**

Please fax completed referral at 613-230-8884