Nebraska Medicine

Interventional Radiology Services Order

PATIENT NAME: ______________________ (first name, middle initial, last name) *Required*
DOB: __________ *Required*
TODAY'S DATE: __________ *Required*

REFERRING PHYSICIAN: ______________________ *Required*
DAY PHONE: __________ *Required*
CELL: __________

CLINIC BACK LINE PHONE: ______________________
FAX #: __________ *Required*

PHYSICIAN SIGNATURE: ______________________ *Required*
PROVIDER ID: __________

INDICATION: __________ *Required*
LOCATION ON BODY: __________

SPECIAL REQUESTS/INSTRUCTIONS: ______________________

☐ **Abscess** - ☐ Aspiration ☐ Drain placement ☐ Drain check

☐ **Biopsy** - *Choose type of biopsy below*

☐ **Abdomen/Pelvis**

☐ **Bone Lesion**

☐ **Bone Marrow**

☐ **Kidney - Type:** ☐ Native ☐ Transplant ☐ Mass

☐ **Liver - Type:** ☐ Nodule ☐ Random ☐ Transjugular

☐ **Lung - Laterality:** ☐ Left ☐ Right

☐ **Lymph Node - Location:** ☐ Axillary ☐ Cervical ☐ Inguinal ☐ Mesenteric ☐ Retroperitoneal ☐ Supraclavicular ☐ Other: __________

Laterality: ☐ Left ☐ Right ☐ Not Applicable

Type: ☐ Core ☐ FNA ☐ Per Interventional Radiologist

☐ **Spine** - ☐ Disc ☐ Vertebrae **Spine Level:** __________

☐ **Thyroid - Laterality:** ☐ Left ☐ Right ☐ Bilateral

☐ **Other:** __________

☐ **Line** ☐ **Port**

Type: ☐ Non-Tunneled ☐ Tunneled ☐ PICC ☐ Other: __________

☐ **Placement**

Laterality: ☐ Left ☐ Right ☐ Per Interventional Radiologist

Line Indication: ☐ Apheresis ☐ Dialysis ☐ Medications ☐ TPN ☐ Vascular Access ☐ Other: __________

Port Indication: ☐ Apheresis ☐ Chemotherapy ☐ IV Infusions ☐ Other: __________

Apheresis Port Type: ☐ Bard Powerflow ☐ Vortex Port ☐ Other: __________

☐ **Removal - Reason:** ☐ Treatment Complete ☐ Infected ☐ Other: __________

☐ **Check - Reason:** ☐ Unable to Aspirate ☐ Unable to Flush ☐ Other: __________

Has cath flow been attempted? ☐ Yes ☐ No

Replace if necessary? ☐ Yes ☐ No

Indication if replacement necessary: ☐ Apheresis ☐ Chemotherapy ☐ IV Infusions ☐ Other: __________

If Apheresis replacement - Port Type: ☐ Bard Powerflow ☐ Vortex Port ☐ Other: __________

Location: ☐ Left ☐ Right ☐ Per Interventional Radiologist

☐ **Paracentesis** ☐ **Thoracentesis**

Type: ☐ Diagnostic ☐ Therapeutic ☐ Diagnostic/Therapeutic

Indication: ☐ Infection ☐ Malignancy ☐ Other: __________

Thoracentesis Location: ☐ Left ☐ Right ☐ Per Interventional Radiologist

Frequency for Therapeutic: ☐ Once ☐ Weekly ☐ Every other Week ☐ Monthly ☐ Other: __________

Paracentesis therapeutic max mL to drain: __________

☐ **Tube** - *Choose type of tube below*

☐ **Chest Tube**

Action: ☐ Placement ☐ Removal

Location: ☐ Left ☐ Right Specifics: __________

Indication for placement: ☐ Pneumothorax ☐ Pleural Effusion ☐ Empyema

☐ **Feeding Tube**

☐ Placement ☐ Removal ☐ Check/Replace

Tube Type: ☐ G-Tube ☐ G-J Tube ☐ J-Tube ☐ Other: __________

Indication for placement or replacement: ☐ Feeding ☐ Decompression ☐ Other: __________

Indication for check: ☐ Leaking ☐ Clogged ☐ Other: __________

☐ **Nephrostomy**

Location: ☐ Left ☐ Right ☐ Transplant

☐ **Biliary**

☐ **Cholecystostomy/Gallbladder**

☐ **PleurX**

Location: ☐ Abdomen ☐ Chest/Pleural ☐ Other: __________

Location: ☐ Left ☐ Right

☐ **Other Tube Type:** __________

☐ **Vascular**

Choose type below

☐ **Arterial** ☐ **Venous** ☐ **AV Fistula/Graft**

☐ **TIPS** - ☐ New ☐ Revision

☐ **BRTO**

☐ **IVC Filter** - ☐ Placement ☐ Removal ☐ Other: __________

☐ **Procedure Not Specified** - *indicate request above in special requests/instructions*

☐ **Labs with IR Procedure**

Body fluid: ☐ Albumin ☐ Cell count with differential ☐ Creatinine ☐ Culture, Bactec bottle ☐ Glucose ☐ Lactate dehydrogenase ☐ pH ☐ Protein ☐ Triglycerides

Culture/Micro: ☐ Acid fast bacilli culture with smear ☐ AFB stain and modified AFB stain ☐ Aerobic culture ☐ Anaerobic w/ aerobic culture ☐ Catheter tip ☐ Fungus culture ☐ Gram Stain ☐ Tissue culture

Pathology/Cytology: ☐ Cytology examination nongenital ☐ Cytology silver stain (fungus) ☐ Pathology examination, surgical

Flow Cytometry: ☐ Cell markers lymphoma, other

☐ **Other:** __________

Specimen Source: __________

Additional Info: __________

Is patient immunocompromised? ☐ Yes ☐ No

CONTACT INFORMATION

Interventional Radiology
p: 402.559.8574 | fax: 402.559.3050
Bellevue p: 402.763.3239 | fax: 402.763.3198

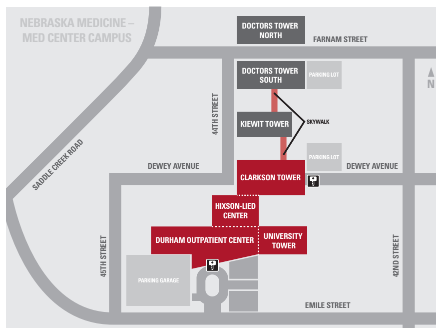
Preauthorization *(for all locations)*
p: 402.559.2110 | fax: 402.559.9887

Nebraska Medicine

Interventional Radiology Services Order

	MRI 1.5T	MRI 3T	PET-CT	CT	US	X-RAY	MAMMO 3D	DEXA	NUC MED	FLUORO	IR SUITE
Hixson-Lied Center	●	●		●							●
University Tower			●		●	●		●	●	●	
Clarkson Doctors Building South						●					
Olson Center for Women's Health (Durham Outpatient Center)					●		●	●			
Village Pointe Health Center	●			●	●	●	●	●			
Lauritzen Outpatient Center		●		●	●	●				●	
Fred & Pamela Buffett Cancer Center	●	●		●	●	●				●	
Bellevue Medical Center	●			●	●	●	●	●	●	●	●

Locations



Nebraska Medical Center

42nd Street and Dewey Avenue | Omaha, NE 68198
402.559.2500

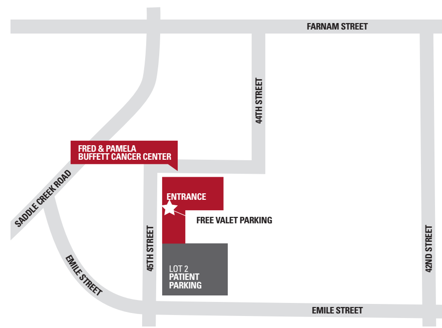
University Tower | 4400 Emile St. (Circle Drive)
402.559.2500
Durham Outpatient Center Entrance
Free Valet Parking*

Clarkson Doctors Building South
4239 Farnam St., Suite 622
402.559.2500 or 402.552.2777
Farnam Street Entrance
Parking Lot Located East of Building

Durham Outpatient Center | 4400 Emile St. (Circle Drive)
402.559.2500 or 402.559.4500
Durham Outpatient Center Entrance
Free Valet Parking*

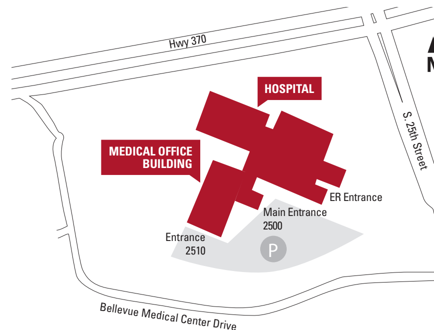
Hixson-Lied Center | 402.559.2500
Durham Outpatient Center or Clarkson Tower Entrance
Free Valet Parking*

* No tipping necessary for valet parking.



Fred & Pamela Buffett Cancer Center

505 S. 45th St. | Omaha, NE 68105
402.559.1900 *same day*



Bellevue Medical Center

2500 Bellevue Medical Center Drive
Bellevue, NE 68123
402.763.3400, option 1

Village Pointe Health Center

111 N. 175th Street | Omaha, NE 68118
402.596.3180 *same day*

Lauritzen Outpatient Center

4014 Leavenworth St. | Omaha, NE 68105
402.559.0769 *same day*

APPOINTMENT INFORMATION Date: ____________ Arrival Time: ________ AM/PM Location: ________________