AI3 ADVANCED IMAGING & INTERVENTIONAL INSTITUTE

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ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

Patient Name: _____ DOS: _____ Time: _____

SSN: _____ Insurance: _____

DOB: _____ Authorization/Referral needed: ☐ yes ☐ no

Patient Telephone: _____ Auth./Referral number: _____

Special Needs? _____ Referring Office Contact: _____

Previous Films: _____ Phone #: _____ FAX #: _____

INTERVENTIONAL PROCEDURES

Diagnosis: _____

Please specify treatment side:

☐ Left ☐ Right ☐ Both Sides

Evaluate and Treat for:

Vascular Procedures:

Arteriogram:
- ☐ Carotid
- ☐ Cerebral
- ☐ Aortogram
- ☐ Aortogram with Run Off
- ☐ Renal
- ☐ Upper Extremity Right or Left
- ☐ Mesenteric / Visceral
- ☐ Other _____
- ☐ (Possible) Balloon Angioplasty
- ☐ (Possible) Stent Placement
- ☐ Clot Thrombolysis ☐ Thrombectomy
- ☐ Endovascular Abdominal Aortic Aneurysm Repair

Venogram:
- ☐ Lower Extremity Right or Left
- ☐ Upper Extremity Right or Left
- ☐ Other _____

- ☐ IVC Filter
- ☐ Port Chest Arm Right or Left
- ☐ PICC Line Single Lumen Double Lumen
- ☐ TIPS
- ☐ Embolization of _____
- ☐ Other _____

Venous Therapy:

- ☐ Radiofrequency Closure® (RFC) Right or Left GSV or LSV
- ☐ Endovenous Laser Treatment (EVLT) Right or Left GSV or LSV
- ☐ Sclerotherapy
- ☐ Phlebectomy

Oncology Procedures:

- ☐ SIR-Spheres®/TheraSphere®
- ☐ Radiofrequency Ablation
- ☐ Chemo Embolization

GI/GU Procedures:

- ☐ G-Tube
- ☐ G-J Tube
- ☐ Biliary Drain
- ☐ Percutaneous Transhepatic Cholagiogram (PTC)
- ☐ Nephrostomy: Right or Left

Pain Procedures:

- ☐ ESI: Right or Left or Central Level _____
- ☐ Hip Injection: Right or Left ☐ SI Injection: Right or Left
- ☐ Facet Block: Level _____ Right or Left
- ☐ Vertebroplasty/Kyphoplasty: Level _____
- ☐ Other : _____

Womens Health:

- ☐ Uterine Artery Embolization (UAE)
- ☐ Fallopian Tube Recanalization
- ☐ Breast Biopsy: Right or Left

Dialysis Therapy:

- ☐ A/V Shuntogram
- ☐ Fistula Declotting
- ☐ Dialysis Catheter Insertion
- ☐ Catheter Clearance

Other Diagnostic Procedures:

- ☐ Thoracentesis: ☐ diagnostic* ☐ therapeutic
- ☐ Paracentesis: ☐ diagnostic* ☐ therapeutic

***For Lab Requests See Reverse Side**

- ☐ BIOPSY of _____ CT or US Guided
- ☐ Thyroid Biopsy: Right or Left
- ☐ Lumbar Puncture
- ☐ Myelogram: Check one: ___ C ___ T ___ L
- ☐ Arthrogram: Location _____
- ☐ Discography: Level _____
- ☐ MRI or MRA of _____
- ☐ CTA of _____
- ☐ Ultrasound of _____
- ☐ Other _____

_____
REFERRING PHYSICIAN SIGNATURE:

_____
REFERRING PHYSICIAN NAME:

_____
DATE:

2730 McMullen Booth Road • Suite 100
Clearwater, Florida 33761
Phone (727) 791-7300 • Fax (727) 723-9010
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Please check appropriate box for lab work requested from collected specimens

- ☐ CYTOLOGY
- ☐ CELL COUNT WITH DIFFERENTIAL
- ☐ AMYLASE
- ☐ LIPASE
- ☐ PROTEIN
- ☐ CEA
- ☐ PH
- ☐ ALBUMIN
- ☐ GLUCOSE

CULTURES

- ☐ ROUTINE WITH GRAM STAIN
- ☐ FUNGUS
- ☐ AFB

OTHER

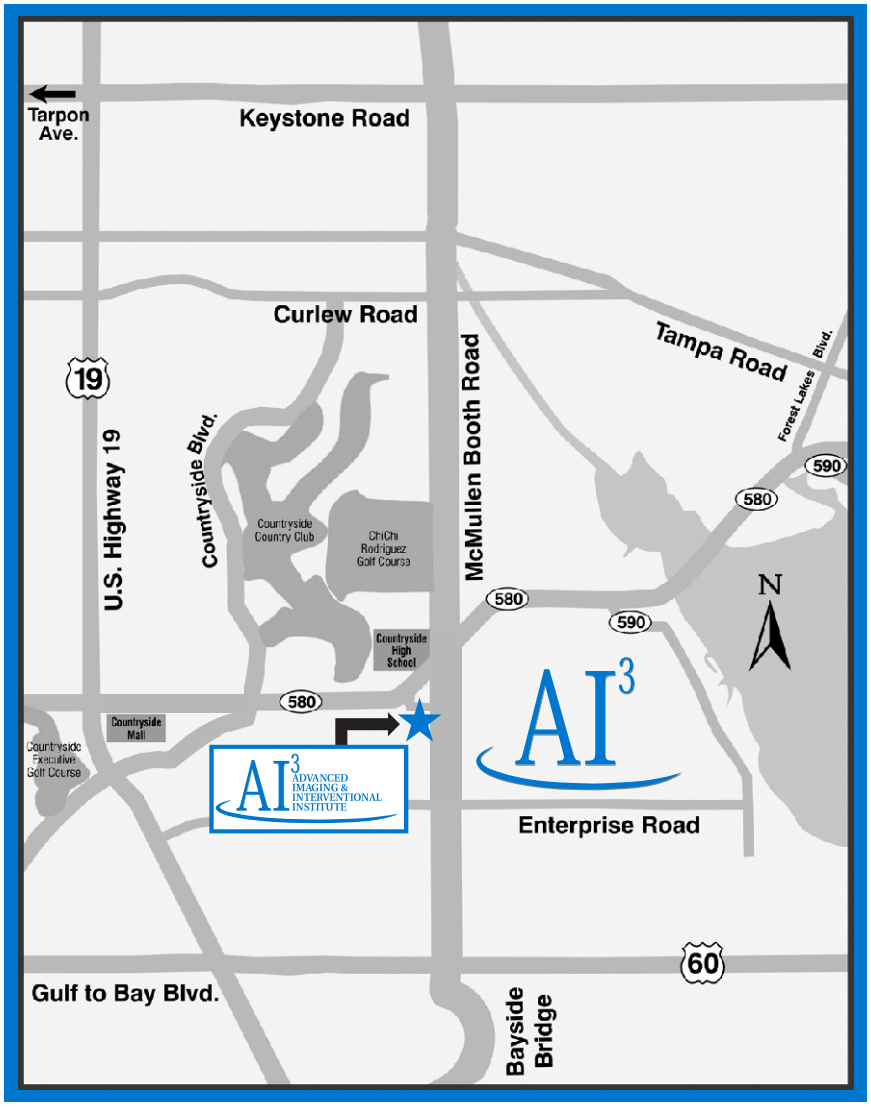
- ☐ _____
- ☐ _____

FOR LUMBAR PUNCTURE AND MYELOGRAM

- ☐ MS PROFILE - NEED 4ML OF FLUID
- ☐ CELL COUNT WITH DIFFERENTIAL
- ☐ GLUCOSE
- ☐ PROTEIN
- ☐ CYTOLOGY

OTHER

- ☐ _____
- ☐ _____



MAP NOT TO SCALE

PROVIDER NUMBERS:

AETNA HMO:	2648373
AETNA PPO:	4593565
AVMED VENDOR:	203364
BC/BS:	31439
MEDICAID:	2501953-00
MEDICARE:	31439A
UHC:	1600774
HUMANA:	10659977161

TAX ID # 59-3727126
NPI # 1639318637

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