Cincinnati Children's
changing the outcome together

3333 Burnet Ave.
Cincinnati, Ohio 45229-3039

INTERVENTIONAL RADIOLOGY REFERRAL FORM

FAX form to 513-636-7794
STAT request call 513-636-8547

In addition to faxing this order, please call 513-636-8547

PATIENT INFORMATION

Patient's Name _____ CCHMC MR# _____

Weight _____ KG Allergies _____

Patient Gender _____ Date of Birth _____ Home Phone _____

Mother's Name _____

Parent/Guardian _____ Phone # (preferred) _____

REASON FOR REFERRAL

History / Symptoms / Potential diagnosis / Special needs:

_____

_____

_____

SERVICES REQUESTED

☐ **Arthrogram**
☐ Shoulder ☐ Hip ☐ Other _____

☐ **Angiogram**
☐ Cerebral ☐ Renal ☐ Other _____

☐ **Bone Biopsy**
Site(s): _____

☐ **Botox Injections**
☐ Submandibular: ☐ Right ☐ Left ☐ Bilateral
☐ Parotid: ☐ Right ☐ Left ☐ Bilateral

☐ **Lumbar Puncture**

☐ **Biopsy**
Site(s): _____

☐ **Percutaneous Nephrostomy**
☐ Right ☐ Left

☐ **Feeding Tubes –** ☐ **placement** ☐ **exchange**
☐ G ☐ GJ ☐ NJ

☐ **Sclerotherapy**
Site(s): _____

☐ **Steroid Injection**
Joint(s): _____
☐ Right ☐ Left ☐ Bilateral

☐ **Spine Intervention**
☐ PARS ☐ Facet Level _____
☐ Right ☐ Left ☐ Bilateral
☐ Other _____

☐ **Rheumatology steroid injection(s)**
See attached sheets
Total pages: ____ including referral form

☐ **Other Procedure:** _____

_____

REQUESTING PRACTITIONER / GROUP

Physician Name _____ Pager # _____

Contact Person _____ Telephone _____

Office Address _____ Fax _____

_____

Signature / Credentials of ordering Practitioner _____ Time: _____ Date: _____

Print Name _____