

**INTERVENTIONAL RADIOLOGY PHYSICIAN ORDER**

1700 13th Street, Everett, WA 98201
Scheduling Phone (425) 258-7000, Option 3
Scheduling Fax (425) 258-7035

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First Middle Initial
Phone: _____ Secondary Contact Number: _____

INSURANCE INFORMATION

Insurance Name: _____ Subscriber Name: _____
Subscriber Id Number: _____ Authorization Required: ☐ Yes ☐ No
Authorization Number: _____

REFERRING PHYSICIAN

Name: _____ Phone: _____
Clinic: _____ Fax: _____
Procedure: _____
Location (I.e. Left, Right, Upper, Lower, Lung) _____
Diagnosis (ICD10): _____ Clinical History: _____
Requested By Date: _____

Physician Signature: _____

Date: _____ Time: _____

Relevant previous imaging studies? ☐ Yes ☐ No Date: _____In Providence PACS: ☐ Yes ☐ No

Allergies: _____ Weight: _____

Is Patient On Blood Thinners ☐ Yes ☐ No If yes, which blood thinner: _____Diabetic: ☐ Yes ☐ No If yes, what medication is the patient taking: _____

Attn: Molly - 206-382-3507