CDS/AUC: G-Code: ______________ Modifier: ______________

Interventional Radiology
Phone #: 850-216-3396
Fax #: 850-216-3645

Musculoskeletal Radiology
Phone #: 850-216-3370
Fax #: 850-216-3645

1600 Phillips Road • Tallahassee, Florida 32308
Main Facility #: 850-878-4127

Procedural Order Form

Patient Name: ______________________________ DOB: ______________

Referring Facility: ______________________ Contact & Direct Line: ______________________

❑ Obtain and Attach Authorization, if Required, or Auth #: ______________________

Pertinent History/Clinical Indication: ______________________

____

*Myelogram / Lumbar Puncture**

❑ CT Myelogram: ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Lumbar Puncture (Attach CSF fluid lab orders)

Biopsies

❑ Thyroid Nodule Biopsy w/FNA:

❑ Right ❑ Left ❑ Isthmus ❑ Bilateral

❑ Salivary / Parotid Gland Biopsy: ❑ Right ❑ Left

❑ Lymph Node Biopsy Location: ______________________

____

❑ Soft Tissue Biopsy Location: ______________________

____

Drainage Procedures

❑ Paracentesis ❑ Thoracentesis: ❑ Right ❑ Left

❑ Therapeutic Only – No Fluid orders

❑ Dignostic – Attach Fluid lab orders

Venous Access – Evaluation

❑ Contrast Injection: ❑ Central Line ❑ PICC ❑ Port

Reason: ❑ No Blood Return ❑ Pain at Injection Site

❑ Unable to Access

❑ Dressing Change

CT Guided Bone Biopsy

❑ Bone Lesion:

Site: ______________

❑ Bone Marrow

Arthrogram & Fluoro Guided Joint Injection

❑ **MR:** ❑ Right ❑ Left

❑ **CT:** Specify Joint: ______________________

Ultrasound Guided Tendon Injections

❑ Right ❑ Left

❑ Gluteus Medius ❑ Biceps Brachii: ❑ Proximal ❑ Distal

❑ Gluteus Minimus

❑ Iliopsoas ❑ Piriformis ❑ Hamstring

Image Guided Joint Injections (US/Fluoro/CT)

❑ Right ❑ Left

❑ Acromioclavicular ❑ Sternoclavicular ❑ Glenohumeral

❑ Trochanteric Bursa ❑ Ischial Bursa ❑ Sacroiliac

❑ Subtalar ❑ Hip ❑ Other: ______________

Ultrasound Guided Joint Aspiration

❑ Right ❑ Left Specify Joint: ______________________

❑ Therapeutic ❑ Diagnostic (Attach Fluid lab orders)

Ultrasound Guided Bakers Cyst Aspiration

❑ Right ❑ Left

Ultrasound Guided Tenotomy/Lavage

❑ Right ❑ Left Site: ______________________

OTHER REQUESTED PROCEDURE: ______________________

____

Physician Signature: ______________________

Printed Physician Name: ______________________

Date: ______________

Please send any pertinent history, lab values, prior imaging reports/images.

H&P is required on Myelograms and Lumbar Punctures.