



101 Sivley Road, Huntsville, AL 35801

P: 256-265-8940 F: 256-265-8748

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REFERRAL/ORDER CHECKLIST (required prior to scheduling)

- | | |
|--|---|
| <input type="checkbox"/> Reason for referral | <input type="checkbox"/> Body system affected |
| <input type="checkbox"/> Procedure requested | <input type="checkbox"/> Signature, date, and time by provider |
| <input type="checkbox"/> Most recent office note and/or history and physical | <input type="checkbox"/> Imaging studies (if not accessible through McKesson) |
| <input type="checkbox"/> Any recent Laboratory and/or imaging reports | |

PATIENT INFORMATION

<input type="checkbox"/> Interpreter	<input type="checkbox"/> Fasting	<input type="checkbox"/> Anticoagulants
Patient Name: _____	Date of Birth: _____	
SSN: _____	Gender: _____	
Phone: _____	Alternate Phone: _____	
Address: _____		

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE

Insurance: _____
 Subscriber: _____
 Policy Number: _____
 Group Number: _____

SECONDARY INSURANCE

Insurance: _____
 Subscriber: _____
 Policy Number: _____
 Group Number: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____
 Facility: _____
 Office Contact: _____
 Phone: _____
 Fax: _____
 Email: _____

REASON FOR REFERRAL/DIAGNOSIS

Reason: _____ Body system affected: _____
 ICD Code: _____
 Allergies (Please circle): YES NO NKDA
 If Yes, please list: _____
 Provider Signature: _____
 Date: _____ Time: _____

CT Scan:

CT Guided Needle Placement
 Location: _____
 CT Guided Catheter/Tube Exchange

Ultrasound:

US Paracentesis
 US Thoracentesis
 US Guided Needle Placement
 US Needle placement w/ Guidance
 US Guidance Interstitial Radio
 US Drain Per/Retr Fld w/Cath Perc
 US Guided Needle Placement w/ Mod
 US Guided Vascular Access

IR:

<input type="checkbox"/> IR Neurovascular Diag 4 Vessel	<input type="checkbox"/> IR Fluoro	<input type="checkbox"/> IR Filter Removal
<input type="checkbox"/> IR Port Placement	<input type="checkbox"/> IR Neurovascular Int	<input type="checkbox"/> IR PICC Child Under 5Yrs Old
<input type="checkbox"/> IR PICC Over 5Yrs	<input type="checkbox"/> IR Cholangiography Post Drainage	<input type="checkbox"/> IR G Tube Replacement
<input type="checkbox"/> IR Embolization	<input type="checkbox"/> IR Filter Placement	<input type="checkbox"/> IR Mesenteric
<input type="checkbox"/> IR Hickman	<input type="checkbox"/> IR Port Removal	<input type="checkbox"/> IR Nephrostomies Bilateral
<input type="checkbox"/> IR Tunneled Dialysis Cath	<input type="checkbox"/> IR Nephrostomy Tube Placement L / R	<input type="checkbox"/> IR Biliary Stent w/Cholangiogram
<input type="checkbox"/> IR Theraspere Y-90 Treatment	<input type="checkbox"/> IR Nephrostomy Bilateral Exchange	<input type="checkbox"/> IR Biliary Tube Exchange
<input type="checkbox"/> IR Stroke	<input type="checkbox"/> IR G Tube/ GJ Tube Placement	<input type="checkbox"/> IR Drainage Cath Change
<input type="checkbox"/> IR Hickman Removal	<input type="checkbox"/> IR Bone Marrow Biopsy	<input type="checkbox"/> IR Percutaneous Liver Biopsy
<input type="checkbox"/> IR Y-90 Mapping	<input type="checkbox"/> IR Tunneled Pleural Cath Aspira Place	<input type="checkbox"/> IR Transjugular Liver Biopsy
<input type="checkbox"/> IR Portacath Injection	<input type="checkbox"/> IR Nephrostomy Tube Exchange L/R	<input type="checkbox"/> IR Gallbladder Drainage
<input type="checkbox"/> IR Misc (NON PICC-Line)	<input type="checkbox"/> IR Biliary Int/Ext	<input type="checkbox"/> IR Paracentesis
<input type="checkbox"/> IR Chest Tube	<input type="checkbox"/> IR Drain Eval	<input type="checkbox"/> IR Pulmonary
<input type="checkbox"/> IR Extremity L/R	<input type="checkbox"/> IR Thoracentesis	<input type="checkbox"/> IR CARTO
<input type="checkbox"/> IR PICC Line Exchange	<input type="checkbox"/> IR Abscess/Fluid Drain Catheter	<input type="checkbox"/> IR Foreign Body Removal
<input type="checkbox"/> IR Drain Transvaginal/Transrectal	<input type="checkbox"/> IR Nephroureteral Stent Change	<input type="checkbox"/> IR IVC
<input type="checkbox"/> IR Tunneled Dialysis Cath Removal	<input type="checkbox"/> IR Nephrostomy Tube Removal	<input type="checkbox"/> IR Triple Lumen Catheter
<input type="checkbox"/> IR Transcath Arterial Chemoembo	<input type="checkbox"/> IR SVC	<input type="checkbox"/> IR Thrombolysis
Other: _____		

Reminders

- Please allow 48 hours for review. After all pertinent referral information is processed, we will send the patient's consultation date/time to the email provided.
- Please be aware that The Clinic for Radiology of Huntsville is located within Huntsville Hospital at the Imaging Services on the ground floor: 101 Sivley Road, Huntsville, AL 35801.
- For Scheduling questions/concerns, please contact Tawanda: (256) 265-8940
- For Nursing questions/concerns please contact our Nurse Navigators, Cheryl and Katie: (256)265-6545

For Huntsville Hospital Office Use Only

TEST DATE: _____

ARRIVAL TIME: _____

Comments: