



Reservation/Intake Form IR Scheduling

IR Nurse 215-453-4188
215-453-4323 (Fax)

Patient Name (last, first)			V#
Date of Service	Patient Phone Number	DOB	SSN
Primary Insurance & Policy Number			Prior Authorization Numbers
Primary Insurance Contact Name & Phone Number		Date	Reference #
Secondary Insurance & Policy Number			Prior Authorization Numbers
Secondary Insurance Contact Name & Phone Number		Date	Reference #
Name of Practice		Office Contact & Phone Number	Fax Number
Ordering Physician Name		Procedure Physician (if different from ordering)	PCP

Patient Status: ☐ Outpatient ☐ Extended Outpatient

Procedure: ☐ Chest Port ☐ Insertion ☐ Removal ☐ Bone Marrow Biopsy
☐ IVC Filter ☐ Insertion ☐ Removal ☐ Tunnel Dialysis Catheter ☐ Insertion ☐ Removal
☐ Percutaneous Nephrostomy Tube ☐ Biopsy _____
☐ Asept Insertion ☐ Pleural ☐ Abdominal ☐ Other: _____
☐ R ☐ L

Procedure / CPT Code(s):

Diagnosis / ICD 10 Code(s):

Allergies: ☐ Shellfish, Iodine or Dye ☐ Latex ☐ Other: _____

Pre-medicate for allergies? ☐ Yes ☐ No

If yes, pre-medicate with: ☐ PredniSONE 20 mg - 3 tabs (60 mg) at bedtime the night before & 3 tabs (60 mg) morning of procedure
☐ DiphenhydrAMINE (Benadryl) 25 mg - 1 tab morning of procedure
☐ Famotidine (Pepcid) 20 mg - 1 tablet morning of the procedure

If patient is on any anticoagulant as noted below, **PLEASE PROVIDE ORDERING DOCTOR NAME.**

Coumadin: ☐ Yes Dr. _____

Pradaxa: ☐ Yes Dr. _____

Xarelto: ☐ Yes Dr. _____

Eliquis: ☐ Yes Dr. _____

ASA: ☐ Yes Dose: _____ Dr. _____

Plavix: ☐ Yes LOAD: ☐ Yes ☐ No Dose: _____ Dr. _____

To schedule procedure we will need:

- H/P or most recent office visit note within last 30 days.
- If patient has had lab work within last 30 days ☐ CBC ☐ BMP ☐ PT/PTT ☐ INR
- If no blood work, please draw or give patient script.
 - Where will patient have labs drawn: _____

Physician Signature _____ Date _____ Time _____

FAX reservation form and hem above to 215 453-4323

