Today's Date: ________________
Request procedure Date: _________

Interventional Neuroradiology Consult Form

Patient's Name: _________________________________ MRN: _____________________

Floor Location:______________ East Newton ____ Menino ___

Procedure Requested:___________________________

Clinical Information (Please be as detailed as possible):

Does the patient speak English? Yes ___ No____ If no, what language? ____________

Can patient consent? Yes __ No __ If no, family member name & contact #:____________________

Does the patient have **Sleep Apnea?** Yes ___ No____ If yes, an anesthesia consult is needed.

Does the patient take **Metformin, Glucophage®?** Yes_____ No ____

Does the patient have **Allergies**? _______________________________

Is the patient an inpatient? Yes ___ No ____

Screening Questions:
Diabetes Yes ___ No ___ **Pregnant** Yes ___ No ____
Coumadin Yes ___ No ___ **Hx Renal Failure** Yes ___ No ____ **DNR Status** Yes __ No __
Heparin Yes ___ No ___

Labs*: Must be within 90 days of the procedure (or 30 days if history of diabetes, renal insufficiency)

Date _________ Platelets _________
Date _________ PT/PTT/INR _____ / _____ / _____
Date _________ Creatinine _____

This form must be completed and faxed before we schedule the procedure.

Please fax to (617) 414-1698.

Completed by: _____________________________________ Pager: __________