PROCEDURE SCHEDULING REQUEST

After procedure is scheduled with the patient, MD's office will be notified of date and time.
Scheduling Dept. 305-598-1555
Scheduling FAX 305-598-1155

FORM COMPLETED AND FAXED:

Date ______________________ Doctor's office ______________________

Name of Person Completing form ______________________ Office Phone ______________________

PATIENT INFORMATION

Name ______________________ ☐M ☐F

Date of Birth ______________________ Social Security # ______________________

Address ______________________

Home Phone ______________________ Work/Cel Phone ______________________

Insurance ______________________ (Please fax copy of insurance card)

Insurance Phone ______________________ Group/ID ______________________

Authorization # ______________________

PATIENT HISTORY

1. Allergies: ______________________

   Verify patient has no Iodine allergies ☐Yes ☐No

2. Does patient take Glucovance or Glucophage? ☐Yes ☐No

3. Does patient take any blood thinning products? (Aspirin, Coumadin, Heparin, Plavix, Vitamin E and/or Herbal Medications)

   (If Yes, circle which medications) ☐Yes ☐No

4. Does patient have recent films? (MRI, CT, X-ray, Ultrasound) (If Yes, tell patient to bring films done outside of VSI)

   ☐Yes ☐No

Please fax with this form (if available). (Must be within 90 days)

PT, PTT, Platelets	**PT, PTT, Chem Profile, CBC**
Thyroid Biopsy	UFE
Chest Port	Vertebroplasty
Steroid Injections	Arteriograms
Tunneled Catheters	IVC Filters

Diagnosis ______________________

Reason for procedure ______________________

PROCEDURE REQUESTED

M.D. Signature ______________________