USE BALL POINT PEN ONLY

Spinal Injection Order

Fax order and information to: 336-328-4416

➢ REQUIRED

* Please arrive @_____ for Registration

Your appt. date is: _____

Your appt. time is: _____

To schedule call (336) 328-3333 Menu option #7

Mon-Thur 7:30am - 6:00pm, Fri 7:30am-5:00pm

➢ Pt. Name : *Last First Middle*	➢ Pt. D.O.B.	➢ Practitioner Signature	➢ Date: _____ ➢ Time:
Pt. Phone #:	Pt. Sex M or F	➢ Print Name of Practitioner	

BOTH Required

➢ Reason for Exam: _____

➢ ICD 10 Code : _____

√	Exam	√	Series of three, only if indicated	CPT(s)		√	Exam	CPT(s)
	Lumbar/Sacro ESI (x1)		(x3) injections	62323			Facet Injection	64493
	Thoracic/Cervical ESI (x1)		(x3) injections	62321			Sacroiliac Joint Injection □R □L	27096

Pre-Authorization required: □YES Authorization number_____ □Not required

[x] Access central line or port if present and use for administration of medications and fluids. Flush per protocol.

[ ] Do NOT access central line or port if present (if checked, this order prevents above order to access central line or port)

ALLERGIES: _____ □NKDA

(If the patient is allergic to IV Contrast, they will need to be pre-treated prior to procedure)

Previous exams and where performed: □X-RAY □ CT □MRI _____

Please hold medication(s)/anticoagulant(s) as follows: **(MUST BE CLEARED BY PRESCRIBING PRACTITIONER)**

□ clopidogrel Bisulfate (Plavix®): 5 days	□ prasugrel (Effient®): 7 days	□apixaban (Eliquis®): 48 hours
□ fondaparinux (Arixtra®): 4 days	□ rivaroxaban (Xarelto®): 1day	□enoxaparin(Lovenox®): 1 dose
□ warfarin(Coumadin®/Jantoven®):4 days	□ dabigatran(Pradaxa®):2days	□edoxaban(Savaysa®): 1 day
□ dipyridamole/aspirin (Aggrenox®): ok if less than 326mg/day, otherwise hold 3 days.		
□(other)		

□ Labs: STAT PT/INR (patient on warfarin (Coumadin®/Jantoven®) □Other_____

Office Contact Person_____ext._____

Phone_____ Fax_____

Please inform us by checking box: Patient is □Diabetic, □Pregnant, or has □Special Needs (please specify)

If you or the patient has any questions before the procedure, please call (336)328-3966, RN in Interventional Radiology.

Please fax this signed order form, imaging reports, especially MRI reports (if not done at Randolph Health), patient's medication list (to include allergies), office notes and history and physical that was completed within 30 days to (336)328-4416. If this order is for an ESI Series, the patient may call scheduling to schedule their 2nd and 3rd injections.

All Orders must be received within 24 hours prior to the procedure or the patient will have to be rescheduled.

Patient Education:

1. Following procedure, the patient CAN NOT DRIVE for the rest of the day. They MUST have a driver to take them home and for the rest of the day.
2. Nothing to eat or drink 3 hours prior to procedure.
3. Someone will need to be with patient at home for 24 hours after the procedure.
4. The procedure will take approximately 30 minutes, but total time at the hospital may be greater than 1 hour.
5. Diabetic patients may notice a temporary increase in blood glucose/sugar levels and should check their levels once daily or more often as directed by their physician for the following week.

For performing practitioner: □IV Saline Lock, only. □Moderate Sedation

□Additional Orders:_____

Randolph Health

PATIENT STICKER