

BALL POINT PEN ONLY

Fluoroscopy Guided Injection Order
Fax order and information to: 336-328-4415

* Please arrive @ _____ for Registration

Your appt. date is: _____

Your appt. time is: _____

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

Monday - Thursday 7:30am - 6:00pm

Friday 7:30am - 5:00pm

- Check One:
- Knee Injection* _____
- Shoulder Injection* _____
- Spinal Injection* _____
- Hip Injection* _____

➤ **REQUIRED**

| | | | |
|--|-------------------|------------------------------|---------------|
| Pt. Name : <i>Last</i> <i>First</i> <i>Middle</i> | ➤ Pt. D.O.B. | ➤ Practitioner Signature | ➤ Date: _____ |
| Phone #: | Pt. Sex M or F | ➤ Print Name of Practitioner | ➤ Time: _____ |
| BOTH Required ➤ Reason for Exam: _____ ➤ ICD 10 Code: _____ | | | |

Please inform us if the patient is a diabetic, is pregnant, or has special needs. If you or the patient has any questions before the procedure, please call (336)625-5151 Ext. 3231/ 3177/ or 3003 and ask to speak to the Nurse in Interventional Radiology.

Allergies: _____

Phone (H) _____ (C) _____ (W) _____

Please obtain consent for the following procedure _____

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

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

Other _____

Please hold medication(s)/anticoagulant(s) as follows:

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

Moderate Sedation: NO YES-start peripheral IV and infuse Normal Saline at 20ml/hr for procedure.

Additional Orders:

Office Contact Person _____ ext. _____

Phone _____ Fax _____

Please fax this signed order form, imaging reports, especially MRI reports (if not done at Randolph Hospital), patient's medication list (to include allergies), office notes and history and physical within 30 days to (336)328-4415. 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:

- 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.
- Nothing to eat or drink 3 hours prior to procedure.
- Someone will need to be with patient at home for 24 hours after the procedure.
- The procedure will take approximately 30 minutes, but total time at the hospital may be greater than 1 hour.
- 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



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Reviewed: 10/19/18

