



RBMC IR CATH LAB CASE REQUEST

Scheduling Phone (541) 222-8765 Scheduling Fax (541) 222-8766

STAT procedures need radiologist approval. If this procedure is needed in less than two weeks due to urgent medical need, please call RAPC support at 541-284-4016 to request physician-to-physician discussion of the case request.

*Procedure	Labs/Imaging Needed Prior	*Procedure	Labs/Imaging Needed Prior
BILIARY CATHETER EXCHANGE <input type="checkbox"/> 47535 CONV EXT BIL DRG CATH TO INT_EXT DRG <input type="checkbox"/> 47536 EXCHANGE BIL DRG CAT PRQ W/IMG GID	CBC, INR, BMP	GASTROSTOMY TUBE REPLACEMENT/EXCHANGE <input type="checkbox"/> 43762 PERQ RPLC GTUBE NOT REQ REVJ GSTRST <input type="checkbox"/> 49452 RPLC GASTRO-JEJUNOSTOMY TUBE PERC	CBC, INR, BMP
BILIARY/ HEPATIC TUBE CHECK <input type="checkbox"/> 47531 NJX CHOLANGIO PRQ W/IMG GID RS&I EXT <input type="checkbox"/> 47532 NJX CHOLANGIO PRQ W/IMG GID RS&I NEW	CBC, INR, BMP	<input type="checkbox"/> GASTRO/JEJUNAL CATHETER EXCHANGE <input type="checkbox"/> JEJUNOSTOMY TUBE EXCHANGE	CBC, INR, BMP
BILIARY STENT PLACEMENT <input type="checkbox"/> 47538 PR PLMT BILE DUCT STENT PRQ EXIST ACCESS <input type="checkbox"/> 47539 PR PLMT BILE DUCT STENT PRQ NEW ACC W/O CATH <input type="checkbox"/> 47540 PR PLMT BILE DUCT STENT PRQ NEW ACCESS W/ CATH		<input type="checkbox"/> INDWELLING TUNNELED PLEURAL CATH W/CUFF PLACEMENT <input type="checkbox"/> INFERIOR VENA CAVA FILTER REMOVAL	CT CBC, INR, BMP
BILIARY CATHETER PLACMENT <input type="checkbox"/> 47533 PR PRQ PLMT BIL DRG CATH W/IMG GID RS&I EXT <input type="checkbox"/> 47534 PR PRQ PLMT BIL DRG CATH W/IMG GID RS&I INT/EXT		<input type="checkbox"/> INFERIOR VENA CAVA FILTER PLACEMENT <input type="checkbox"/> NEPHROSTOMY TUBE PLACEMENT	CBC, INR, BMP
<input type="checkbox"/> CENTRAL VENOUS LINE EXCHG - TUNNELED	CBC, INR, BMP	<input type="checkbox"/> NEPHROSTOMY TUBE EXCHANGE	CBC, INR, BMP
<input type="checkbox"/> CENTRAL VENOUS LINE PLACEMENT TUNNELED	CBC, INR, BMP	<input type="checkbox"/> NEPHROSTOMY TUBE REMOVAL	
CHOLANGIOGRAM <input type="checkbox"/> 47531 PR NJX CHOLANG PRQ W/IMG GID RS&I EXIST ACCESS <input type="checkbox"/> 47532 PR NJX CHOLANG PRQ W/IMG GID RS&I NEW ACCESS		<input type="checkbox"/> NEPHROSTOMY TUBE CONVERSION STENT PLACEMENT URETERAL <input type="checkbox"/> 50433 PR PLMT NEPHROURTRL CATH PRQ NEW ACCESS RS&I <input type="checkbox"/> 50693 PR PLMT URTRL STNT PRQ PRE-EXT NFROS TRACT <input type="checkbox"/> 50695 PR PLMT URTRL STNT PRQ NEW ACCESS W/SEP NFROS <input type="checkbox"/> 50694 PR PLMT URTRL STNT PRQ NEW ACCESS W/O SEP NFROS	CBC, INR, BMP
CHOLECYSTOTOMY TUBE PLACEMENT <input type="checkbox"/> 47533 PR PRQ PLMT BIL DRG CATH <input type="checkbox"/> 47534 PR PQR PLMT BIL DRG CATH W/IMG GID RS&I INT/EXT	CT CBC, INR, BMP		
CHOLECYSTOSTOMY TUBE EXCHANGE <input type="checkbox"/> 47535 CONVERT EXT BIL DRAIN CATH TO INTNL-EXT BIL <input type="checkbox"/> 47536 EXCHANGE BIL DRG CATH PRQ W/IMG GID	CBC, INR, BMP	<input type="checkbox"/> PORT REMOVAL	CBC, INR
<input type="checkbox"/> DIALYSIS CATHETER INSERTION	CBC, INR, BMP	<input type="checkbox"/> PORT IMPLANTATION	CBC, INR, BMP
<input type="checkbox"/> DIALYSIS CATHETER EXCHANGE	CBC, INR, BMP	<input type="checkbox"/> TRANSJUGULAR LIVER BIOPSY	CBC, INR, BMP
<input type="checkbox"/> DIALYSIS CATHETER FROM TEMP TO TUNNEL	CBC, INR, BMP	<input type="checkbox"/> TUNNELED PERITONEAL CATHETER PLACMENT	CT/US, CBC, INR, BMP
<input type="checkbox"/> DIALYSIS CATHETER INSERTION TEMPORARY		<input type="checkbox"/> Y-90 – Includes all orders below: Y-90 PLANNING & Y-90 TREATMENT cases NM Liver SPECT with CT Localization NM Y 90 Therapy with CT Location	CT/MRI CBC, INR, BMP, LFTs, Tumor marker
<input type="checkbox"/> DIALYSIS CATHETER REMOVAL			

***PATIENT NAME:**

***D.O.B.**

***TELEPHONE:**

***Diagnosis/ICD-10 Code(s):** _____

☐ Stat (requires radiologist prior approval, call 541-284-4016) ☐ Routine, most patients scheduled 2-3 weeks from date of complete order

***If patient is anticoagulated and/or on antiplatelet agents, can these agents safely be held for up to 5 days? YES / NO**
 If NO, please plan bridging around patient's scheduled procedure.

***ORDERING PROVIDER SIGNATURE:**

***ORDERING PROVIDER NAME (PRINT):** _____ ***DATE:** _____

ORDER MUST BE PRINTED (cursive writing is not accepted), clear legible and complete.

All fields with [*] are REQUIRED. Incomplete forms will be returned.

REMINDER: Include Demographics, Insurance, Prior authorization & Current H&P including relevant diagnosis

Prior Authorization #

Please ensure you have the most up to date forms / information: <https://www.peacehealth.org/IRupdates>

