UNIVERSITY RADIOLOGY INTERVENTIONAL & NEUROINTERVENTIONAL
RADIOLOGY CLINIC CONSULT REQUEST
Phone: (865) 558-0225
Fax: (865) 540-3857

Patient Name: _____ UT Cerner MRN: _____

DOB: _____ SSN: _____ Home/Cell Phone: _____

Consultation Request

Request Consultation for treatment of: _____(Diagnosis)
Anticipated IR procedure (if known): _____
Ordering Physician: _____
Physician Signature: _____
Physician Phone: _____ Physician Fax: _____

Please include the Following Information as Part of Your Request

- ☐ Copy of Insurance Card
- ☐ Recent History and Physical
- ☐ Last two chart notes
- ☐ Current lab work
- ☐ Radiology Discs & Reports (Select only what you have)
    - CT Scan Date of Most Recent: _____
    - MRI Date of Most Recent: _____
    - Ultrasound Date of Most Recent: _____
    - X-Ray Date of Most Recent: _____
    - Other Date of Most Recent: _____
- ☐ Only radiology reports have been sent. University Radiology will need to request images.

Please Fax Completed Form and Attachments to (865) 540-3857

Some Interventional Radiology procedures will require imaging procedures performed within a certain period of time. There may be a need to request additional imaging depending on how recent your patient's last exam was performed.

All relevant information regarding your patient's condition will need to be received by our office ***before*** a consultation is scheduled to ensure reviewing/approval by the Interventional Radiologist.

For Office Use Only:
Appointment Date/Time: _____ Provider: _____

***We have informed your patient of this appointment date and date. We have mailed a new patient packet to include appointment information as well as a map.*

****If this is a request for a procedure that does not require an office visit prior– the referring office will be responsible for obtaining the preauthorization****

FLIP TO BACK FOR BIOPSY ONLY ORDER

UNIVERSITY RADIOLOGY INTERVENTIONAL & NEUROINTERVENTIONAL
RADIOLOGY DEPARTMENT REQUEST
Phone: (865) 305-9029
Fax: (865) 305-6766

Patient Name: _____ UT Cerner MRN: _____

DOB: _____ SSN: _____ Home/Cell Phone: _____

Biopsy ONLY Request

Request Consultation for treatment of: _____(Diagnosis)
Anticipated biopsy location: _____
Ordering Physician: _____
Physician Signature: _____
Physician Phone: _____ Physician Fax: _____

Please include the Following Information as Part of Your Request

- ☐ Copy of Insurance Card
- ☐ Last two chart notes
- ☐ Radiology Discs & Reports (Our providers require the images to review prior to scheduling)
    - CT Scan Date of Most Recent: _____
    - MRI Date of Most Recent: _____
    - Ultrasound Date of Most Recent: _____

Please Fax Completed Form and Attachments to (865) 305-6766

This request is handled directly through the IR Department and the patient is not seen in the IR Clinic prior to scheduling – therefore,the referring office will be responsible for obtaining the preauthorization*

All relevant information regarding your patient's condition will need to be received by our office ***before*** a procedure is scheduled to ensure reviewing/approval by the Interventional Radiologist.

For Office Use Only:
Appointment Date/Time: _____ Provider: _____

We will contact your patient to inform them of this appointment information as well as any preoperative instructions.

FLIP TO FRONT FOR CLINIC ORDER