

PHYSICIAN'S EXAM REQUEST FORM

PATIENT NAME _____ DOB _____ SS# _____
ADDRESS _____ PHONE _____ ALT# _____
CITY, STATE _____ ZIP _____
DIAGNOSIS _____ ICD 9 _____

CONSULTS

- Peripheral Vascular Disease*
- Carotid Arterial Disease / Carotid Stent*
- Renovascular Disease*
- Abdominal Aortic Aneurysm*
- Biopsy*

Venous Disease

- Thrombolysis for DVT*
- IVC Filter Placement*
- Spider Vein Therapy*
- Varicose Vein Therapy*
- Testicular Vein Embolization*

Oncologic Intervention

- Radiofrequency Ablation of Tumor*
- Chemoembolization of Tumor*
- Intrathecal Chemotherapy Administration*

PROCEDURES

Angiography

- Angioplasty/Stent*
- Carotid Angiography*
- Carotid Stent*
- Cerebral Angiography*
- Abdominal Angiography with Run off*
- Renal Angiography*
- Carbon Dioxide Angiography*

Venous Access Device Placement

- PICC*
- Port*
- Groshong*
- CVL*
- Dialysis Catheter Tunneled*
- Temporary Dialysis*
- Dialysis Catheter Temporary*

Pain Management

- Kyphoplasty*
- Vertebroplasty*
- Epidural*
- Nerve Root*
- Facet Injection*
- SI Joint*
- Hip Joint*

- Hemodialysis Access Management*
- Percutaneous Gastrostomy Tube*
- Fallopian Tube Recanalization*

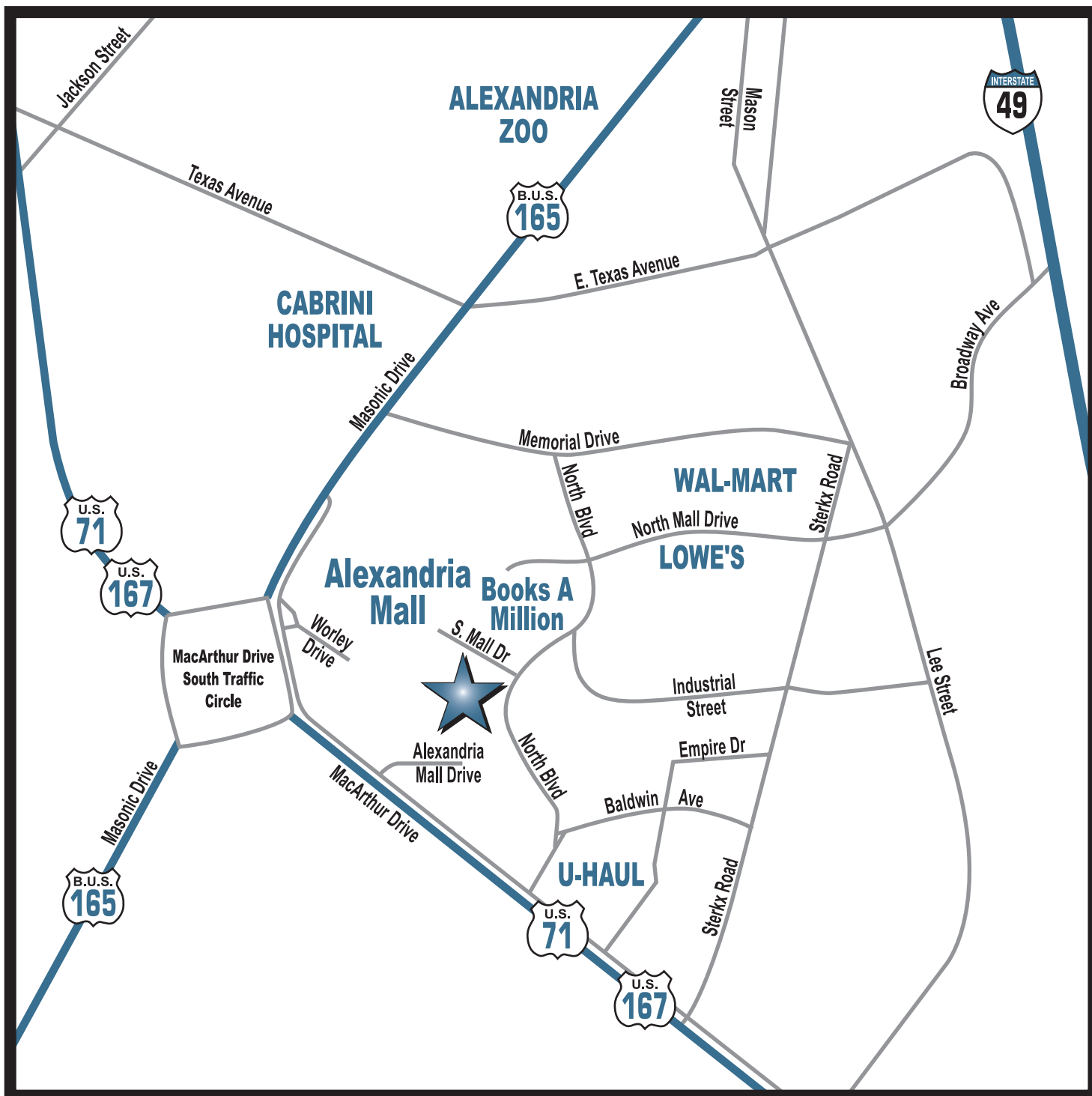
Miscellaneous Procedures

- Thoracentesis*
- Paracentesis*
- Lumbar Puncture*

SPECIAL INSTRUCTIONS _____

RETURN
APPOINTMENT _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____



MIIGS

MINIMALLY INVASIVE IMAGE
GUIDED SPECIALISTS

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