

IR/Centralized Scheduling STAFF ONLY

Outside Images and Reports: Yes / No / NA CPT Code: _____ H&P Required within 30 days of appt for sedation

IR Approved Procedure and/or Notes: _____ Sedation / No Sedation IR Initials & Date: _____



Interventional Radiology Procedure Order Form

Patient Name: _____ D.O.B: _____ Patient Weight: _____ Patient Phone : _____

Procedure Requested (Must include location and laterality, example: Left Thyroid Nodule Biopsy):

_____ Diagnosis: _____ ICD10 #: _____

Labs Needed: ☐ Pathology ☐ Cultures Other _____

Preauthorization Required: For all patients, regardless of Insurance provider (private or Medicare/Medicaid), must have a preauthorization or “no authorization required” documentation for **IR provided CPT code**

Scheduling Team will Call Back with the approved Procedure for Your Office to Obtain the Preauthorization

If NO Preauthorization Required Reference: _____ **Must Send Copy of reference**

Provider Name (Printed): _____ Provider Signature: _____

Date Signed: _____ Time Signed: _____ Direct Phone #: _____ Office Contact: _____

Please send H&P, demographics sheet, copy of insurance information & preauthorization, and the patient's medication list.

Patient Medical Information (Please fill this out entirely)

History of Cancer: ☐ Yes ☐ No If Yes, what type? _____ Date of Diagnosis: _____ Last Treatment: _____

Is the Patient on Blood Thinners? ☐ Yes ☐ No Blood Thinner Medication: _____

Has the Patient had PLTS, PT, INR, and PTT Drawn Within the Last 30 days? ☐ Yes ☐ No **(If Yes, Please Send Results)**

Date of History & Physical: _____ **Must be within 30 days of appointment to receive moderate sedation**

Is the Patient Able to Sign a Consent Form? ☐ Yes ☐ No If No, Patient's Representative Information:

Representative Name: _____ Phone : _____

Does the Patient Have Imaging Studies Outside of Midland Health? ☐ Yes ☐ No Where: _____

****Please send Outside Imaging Records to: Midland Health – Attn: Interventional Radiology Dept. 400 Rosalind Redfern Grover Parkway Midland, Texas 79701**

(Patient Label)

Patient Name:

Patient DOB:

MR #:

Acct #:

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Radiology Department

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Effective Date: 09/23/2026

Last Review Date: 09/23/2026

Scan to: Physician Order