



UNIVERSITY INTERVENTIONAL 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****



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

FLIP TO BACK FOR BIOPSY ONLY ORDER

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: _____



UNIVERSITY
RADIOLOGY

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

UNIVERSITY INTERVENTIONAL RADIOLOGY

CLINIC CONSULT REQUEST

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FLIP TO FRONT FOR CLINIC ORDER