Interventional Radiology



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1001 Johnson Ferry Road Atlanta, GA 30342 404-785-4775

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ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name	Date of Birth	Phone Number
Address	City, State	Zip
Insurance/Medicaid Plan	Policy & Group#	'
Authorization# (Please also fax a copy of insurance card, front and back, with this	order) Guarantor's Email	
Reason For Exam (Signs, Symptoms, Chief Complaint)		
Exam to be Completed (If procedure is a Lumbar Puncture, Please notate below if opening/closing pressures are necessary along with CSF samples or CSF samples alone.)		
Lab Orders (If any specimens are to go to the lab, please place Lab Orders below. If this section is not completed, no studies will be completed by the lab.)		
ALL OFFICE CONTACT INFORMATION REQUESTED IS MANDATORY		
Ordering Physician's Printed Name	Practice Name	
Ordering Physician's Signature	Office Contact	
Date Signed	Backline Phone	Fax
PCP Name (if different):	PCP Fax	
Interventional Radiology		
Special Instructions Date / Time Req: Confirmed Appt: Foster Child:	Order Comments / Other	