CENTRELAKE IMAGING & ONCOLOGY
VASCULAR & INTERVENTIONAL CENTER

ACCREDITED ASF SURGERY FACILITY

**West Covina**
1700 W West Covina Pkwy
West Covina, CA 91790

**Downey**
10226 Lakewood Blvd
Downey, CA 90241

MAIN: (626) 773-7718
(562) 287-7208

FAX: (626) 962-7009
HOURS: M-F, 8AM-5PM

Name:_____ DOB:_____ Day Phone:_____ Today's Date:_____

Insurance Carrier:_____ Insurance ID:_____ IPA:_____

VRE / MRSA? __ Yes __ No IV Contrast Allergy?__ Yes __ No Coumadin/blood thinners? __ Yes __ No; Type:_____

Referring Physician:_____ Phone #:_____ Fax #:_____

☐ Routine ☐ STAT ☐ Send Report Copy to Physician, Name/Fax:_____

## ALL VENOUS ACCESS

- ☐ Peripherally inserted central catheter (PICC line)
- ☐ Portacath / Mediport
- ☐ Triple lumen non-tunneled catheter (central line)
- ☐ Remove catheter, Specify: _____
- ☐ Repair or exchange catheter, Specify: _____
- ☐ Catheter evaluation, Specify: _____

## VASCULAR PROCEDURES

- ☐ Aortogram: ____ Thoracic ____ Abdominal
- ☐ Aorta with bilateral extremity run-off: ___Upper ___Lower
  ___ Right Only ___ Left only
  ___ With intervention if indicated_____
- ☐ Renal angiogram
  ___ With intervention if indicated_____
- ☐ Other Angiogram, Specify:_____
  ___ With intervention if indicated_____
- ☐ Upper extremity venogram: ___ Left ___ Right ___ Bilat.
- ☐ Lower extremity venogram: ___ Left ___ Right ___ Bilat.

## DAILYSIS ACCESS MANAGEMENT

- ☐ Fistulogram - AV fistula / graft evaluation
  - with intervention / declot if indicated
- ☐ Non-tunneled catheter for dialysis (Quinton)
- ☐ Tunneled catheter for dialysis (Permacath)
- ☐ Tunneled peritoneal dialysis catheter

## BIOPSY

- ☐ Specify Biopsy Site: _____

## JOINT ASPIRATION/INJECTION

- ☐ Joint aspiration, Specify Site: _____
- ☐ Intra-articular steroid injection,
  Specify site: _____

## DRAINAGE

- ☐ Thorocentesis
  ___ Diagnostic ___ Theraputic
  ___ Left ___ Right
- ☐ Paracentesis
  ___ Diagnostic ___ Theraputic
- ☐ Placement of permanent drainage catheter
  ___ Pleural ___ Peritoneal
  ___ Left ___ Right ___ Bilateral
- ☐ Abscess/fluid collection drainage
  Specify Site: _____
- ☐ Removal of drainage catheter
  Specify Site: _____
- ☐ Tube check

## SPECIALIZED PROCEDURES

- ☐ Kyphoplasty consult
- ☐ IVC filter ___ Placement ___ Removal
- ☐ Lumbar puncture ___ Opening pressure: Y / N
- ☐ Myelogram ___ Lumbar ___ Thoracic ___ Cervical
- ☐ Varicose vein evaluation and treatment

## OTHER INTERVENTIONAL PROCEDURE

_____

_____

***** Required : PT/PTT/INR; CBC & Chem 7 labs within 30 days. Please fax lab results to (626) 962-7009. *****

## WRITTEN DIAGNOSIS, SYMPTOMS, REASON FOR EXAM(S), SPECIFIC AREA(S) OF INTEREST, SPECIAL INSTRUCTIONS

Please list any signs/symptoms and fax all clinical information and prior studies which are pertinent to this exam to (626) 962-7009. If your study is not listed above please contact our office at (626) 773-7718 or (562) 287-7208.

Please Include ICD Code(s):

_____

_____

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Referring Provider Signature (Required for Exam)