



\*Indicates Required Fields \*Patient Name: \_\_\_\_\_ \*Today's Date: \_\_\_\_\_

\*Patient DOB: \_\_\_\_\_ \*Patient Day Phone / Cell: \_\_\_\_\_

\*Referring Provider (Name): \_\_\_\_\_

\*Referring Provider (Signature): \_\_\_\_\_ CC Provider: \_\_\_\_\_

Stat Results via:  Phone call to: \_\_\_\_\_  Fax to: \_\_\_\_\_

Creat. Level: \_\_\_\_\_ Date drawn: \_\_\_\_\_ or  I-STAT – If indicated (Check box)

Insurance Company: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

\*Clinical HX/DX and Special Instructions: \_\_\_\_\_

FOR AUTHORIZATION SUPPORT  
Copy front and back of insurance card  
and fax appropriate physician notes

**VERTEBRAL FRACTURES**

**VERTEBRAL FRACTURE AUGMENTATION**

- Consult/Treat
  - Thoracic fracture(s)
  - Lumbar fracture(s)
- Patient must have all 3 of the following to be a candidate:
- Moderate to severe pain
  - Significant functional impairment
  - Failed trial of conservative treatment

**INTERVENTIONAL ONCOLOGY**

**RADIOFREQUENCY ABLATION/CRYOABLATION**

- Consult/Treat
- Liver  Lung
- Kidney  Bone
- Other: \_\_\_\_\_

**TRANSARTERIAL CHEMOEMBOLIZATION**

- Consult/Treat
- Hepatoma
- Mets \_\_\_\_\_

**YTTRIUM 90 RADIOEMBOLIZATION**

- Consult/Treat
- Hepatoma
- Mets \_\_\_\_\_

**VASCULAR INTERVENTIONS**

**AORTO-ILIAC/LOWER EXTREMITY ARTERIAL OCCLUSIVE DISEASE**

- Consult/Treat
- Hx: \_\_\_\_\_

**RENAL ARTERY STENOSIS**

- Consult/Treat
- Hx: \_\_\_\_\_

**CAROTID OCCLUSIVE DISEASE**

- Consult/Treat
- Hx: \_\_\_\_\_

**MESENTERIC ARTERIAL OCCLUSIVE DISEASE**

- Consult/Treat
- Hx: \_\_\_\_\_

**AORTIC ARCH BRANCH STENOSIS**

- Consult/Treat
- Hx: \_\_\_\_\_

**ABDOMINAL AORTIC ANEURYSM**

- Consult/Treat
- Hx: \_\_\_\_\_

**THORACIC AORTIC ANEURYSM**

- Consult/Treat
- Hx: \_\_\_\_\_

**DEEP VEIN THROMBOSIS/VENOUS THROMBOLYSIS**

- Consult/Treat
- Hx: \_\_\_\_\_

**OTHER:**

\_\_\_\_\_  
\_\_\_\_\_

**GYNECOLOGICAL INTERVENTIONS**

**UTERINE FIBROID EMBOLIZATION**

- Consult/Treat

**PELVIC CONGESTION SYNDROME**

- Consult/Treat

**OTHER**

**MALE VARICOCELE EMBOLIZATION**

- Consult/Treat

**PROSTATE ARTERY EMBOLIZATION**

- Consult/Treat

**TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT**

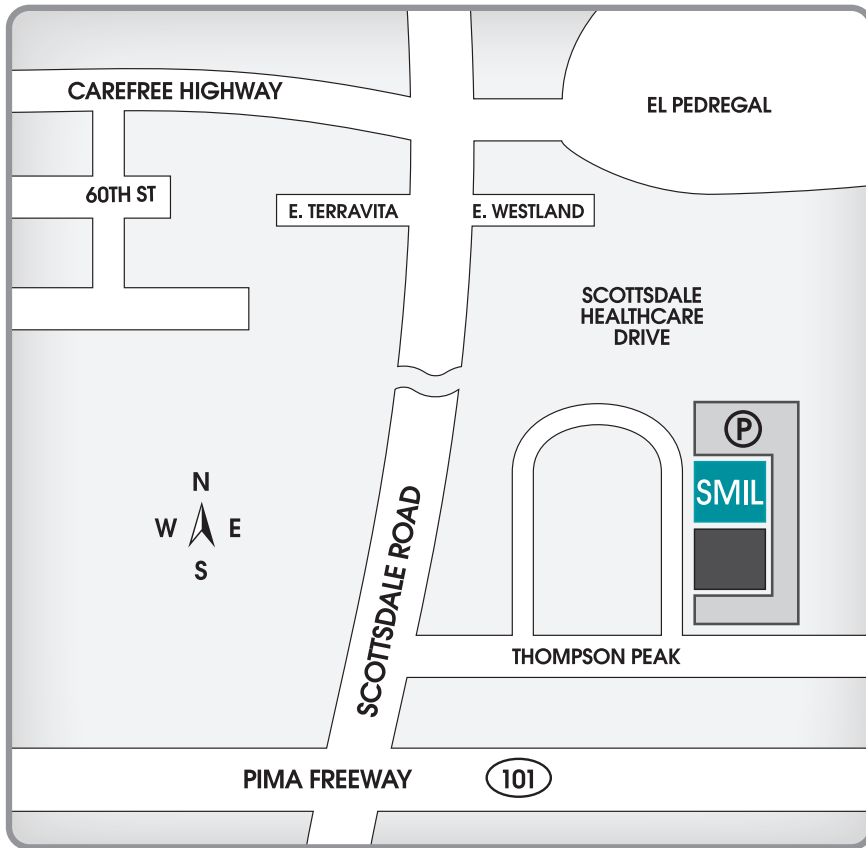
- Consult/Treat
- Other: \_\_\_\_\_

**TO SCHEDULE A PATIENT FOR ANY INTERVENTIONAL CONSULTATION:**

Please fax the following information to 480-657-3491:

- This completed order form
- H&P from referring physician (Must be within 30 days)
- Diagnosis code: \_\_\_\_\_
- Copy of patient's insurance cards
- Copy of imaging reports (unless SMIL)

Please refer to back page for Interventional procedures that are to be scheduled directly through HonorHealth.



SMIL INTERVENTIONAL SCHEDULING: (480) 425-4150  
 SMIL INTERVENTIONAL FAX: (480) 657-3491  
 eSMIL.com

**INTERVENTIONAL RADIOLOGY:**  
**Thompson Peak Medical Plaza**  
 20201 N. Scottsdale Healthcare Dr.  
 Ste. 190  
 Scottsdale, AZ 85255

**INTERVENTIONAL PROCEDURES TO BE SCHEDULED DIRECTLY THROUGH HONORHEALTH**

The following procedures are performed by SMIL Vascular and Interventional Radiology Physicians but should be scheduled directly with HonorHealth.

**HonorHealth**  
 IR Scheduling Phone:  
 623-580-5800

**HonorHealth**  
 IR Scheduling Fax:  
 602-331-5765

**BILIARY INTERVENTIONS:** Percutaneous Cholangiography, Stone Extraction, and Stent Placement

**DIALYSIS GRAFT AND FISTULA INTERVENTIONS**

**GASTROINTESTINAL FEEDING TUBES**

**INFERIOR VENA CAVA FILTER PLACEMENT AND REMOVAL**

**FALLOPIAN TUBE RECANALIZATION**

**PERCUTANEOUS ABSCESS DRAINAGE**

**PERCUTANEOUS IMAGE-GUIDED BIOPSY**

**COMPREHENSIVE VENOUS ACCESS SERVICE, INCLUDING:** PICC, Chest Port, and Dialysis Catheters

**UROLOGIC INTERVENTIONS:** Percutaneous Antegrade Pyelography, Nephrostomy Tube Placement, Ureteral Stent Placement

**GASTROINTESTINAL BLEEDING INTERVENTIONS:** Embolization, Infusion Therapies

**THORACENTESIS**

**PARACENTESIS**