

## **RADIOLOGY BIOPSY ORDER**

Fax order and H&P to 763.792.1979 H&P needed for sedation purposes.

	Patient Inform	nation		
Patient name:	Date of birth: Phone:		Phone:	
List of known malignancies:	Clinical concern:			
Comparison imaging: ☐ No ☐ Yes - list typ	pe of imaging and location of exa	ım Previ	ous biopsy: 🗖	No ☐ Yes - date/location
☐ Current medication list <u>attached</u> , include	ding anticoagulants and any k	nown allergies. O	r list:	
	Provider Information ar	nd Biopsy Orde	r	
Ordering provider:	Clinic:	Clinic p	ohone:	Clinic fax:
Patient's primary care clinic:	Patient	's primary healthca	are provider: _	
Clinic contact completing this form:	Phone nur	mber:	_ Fax # for PA	THOLOGY results:
Biopsy requested:				□ R □ L (if known)
Comments:				
SIGN Ordering provider signature:				
Most ultrasound-guided biopsy procedures				
	Midwest Radiology St	aff Completes		
Reviewed by:		Da	ate:	
<b>Biopsy approved:</b> □ Yes □ No □ Cor	re 🔲 FNA 🔲 Adequacy Check	<		
High Risk Biopsy: ☐ Yes ☐ No Action	n:			
Modality: □ CT □ US □ Fluoro □ IR	Procedure by:	Available radiolog	ist 🔲 Interve	ntional radiologist
Patient requires pre & post-care:   Yes	☐ No Series:		Image	·
Anticoagulant therapy: ☐ No ☐ Yes —	→ □ Ultra low risk □ Low risk	☐ Moderate risk	☐ High risk	
Anticoagulant:				
Comments:				
commends.				
Performing location (MWR, Mercy, Unity so Procedure to be performed at:	cheduler): 1. Call pt & schedule	e 2. Call ordering	g provider with	n date/time of scheduled procedu
☐ Midwest Radiology Suburban Imaging	- Coon Rapids US guidance only	(scheduling: 763.	792.1999 / fax:	651.681.1280)
☐ Mercy Hospital (IR scheduling: 763.236.2		Sched	duling notes:	
☐ Unity Campus (IR scheduling: 763.236.4		2 3.10	J	
☐ First available at Mercy Hospital or Uni	ty Campus			