PHONE: (305) 243-2960 **Invasive Procedures Only** **FAX: (305) 243-6497**

Patient Name:____________________ ***D.O.B.*** ________ ***SS#*** ________

Home Phone:____________ ***UM MR#*** ________ ***Last Visit Date:***________

Requested Date:______ ***Time:***____ ***Office Contact:***________ ***Phone:***________

Insurance Name:________________ ***Authorization#***______________

(Authorized Number should be provided by the Ordering Physician's Office)

Previous Films: ☐ ***UMHC*** ☐ ***Outside (Provide any Previous Outside Studies)***

Procedure Requested:____________________________

Reason for Procedure:____________________________

Diagnosis:________________________________

Ordering Physician's Name:____________________ ***Beeper #:***______

Ordering Physician's Signature:________________________

(MD Name & Signature, Patient Diagnosis and Reason are required to schedule any procedure)

Obtain the following:

- ***CBC W/Platelet Count***
- ***PT (Prothrombin Time)***
- ***PTT (Partial Thromboplastin Time)***

(Labs must be obtained and faxed no more than 7 days prior to schedule date)

Allergies:________________________________

Diabetic : ☐ ***Yes*** ☐ ***No Diabetes under control with:***______________

Blood Thinners: ☐ ***Yes*** ☐ ***No If Yes, list blood thinner:*** ______________

All original UMSylvester medical records are the property of UMSylvester and maintained by the Health Care Provider's Record Custodian. Copies of this form must be destroyed upon the completion of its temporary use. To receive a copy of your health information please contact your Health Care Provider's Record Custodian or the UMSylvester HIM Release of Information department at (305) 243-5272.

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HOSPITAL & CLINICS
Miami, FL 33136 www.med.miami.edu (305)243-1000

VASCULAR/ULTRASOUND DIAGNOSTIC CENTER PHYSICIAN ORDER FORM FOR INVASIVE PROCEDURES

Form A1400057

Revised 3/16/05

NAME:____________________

____________ ☐ UMMG # ☐ MRN

AGE:________ DOB:____/____/____

DATE OF SERVICE:______________

WHITE – CHART YELLOW – DEPARTMENT FILE