Hilo Medical Center
We Care for Our Community

INTERVENTIONAL RADIOLOGY PROCEDURE PROTOCOL

Patient Name: _____ DOB: _____

Requested IR Procedure: _____ MRN: _____

Radiologist to specify Procedure, *if different than indicated above*:

Place identification sticker/label here

_____

Requested by Dr. _____ Direct PH #: _____ Date of Request: _____

_____Images requested for TELERAD Date forwarded to Radiologist for protocol: _____

Radiologist Review:

History and Images reviewed by Dr. _____ Date Reviewed: _____

Modality for procedure: __Angio* __CT* __US __Fluoro __Other *(specify)*_____

*also want Ultrasound? __YES __NO

__Unable to do at HMC *Reason:*

___IR Required ___Any Rad ___Specific Rad: _____ ___PICC Team

Short Stay Admission required? __YES __NO Notify Pathology (Lab)? __YES __NO

Lab work needed: _____

Patient Instructions:

___ Estimated time at Hospital including recovery: _____
___ Need someone to drive you home
___ Discontinue Asprin or any blood thinners 3 days prior to procedure
___ NPO from _____
___ Other _____

Clinic before procedure?

__ Yes __ No
__In Person __Telehealth
Clinic Appointment Date: _____

Clinic Appointment Time: _____

Arrangements:

Procedure to be done by: Dr. FUNG / Dr. WALTERS
circle one
or indicate other IR:

Date of Procedure: _____
Time of Procedure: _____
Time of Check-in: _____

Notifications:

___Patient
___Referring Physician
___Emailed Short Stay
___Faxed Short Stay

Pathology (Lab)
Spoke with: _____ Date: _____
Bone Marrow Biopsy:
___Special appointment time

Scheduling Checklist:

___Imaging Requisition

___Admit Orders for SS, date: _____
Must include "Admit to Short Stay", "Start IV", and discharge instructions / Admitting provider's signature, date & time within 30 days of appointment

___H&P for SS, date: _____
Must include Admitting provider's signature, date & time within 30 days of appointment

___Lab results, collection date: _____

___Medication List ___Consent for procedure

Additional Notes:

Prior Authorization Checklist:

CPT Code(s): _____

Prior Auth required? ___YES ___NO

Info verified with: _____

If prior auth required, forward to Auth team

Auth status: ___Approved ___Denied

___Other (specify) _____

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Pre-Op/Pre-Procedure Document Checklist

Please fax completed documents to (808) 974-7068 or send to Short Stay
Call Short Stay 7:30-4pm M-F at (808) 932-3476 for assistance.

Patient:_____ **DOB**:_____ **Patient Phone #**: _____
Admitting Physician: _____ **Date of Service**:_____
Time patient instructed to check in at HMC Short Stay: _____
(Please have patient check-in 2 hours prior to procedure for adequate prep time.)

Doctor Office Reminders: (Complete prior to date of service.)
- ■ INSURANCE PRE-AUTHORIZATION ■ Confirmation from insurance
- ■ Fax to Admitting. Date:_____ Time:_____ Initial_____ 974-6869
- ■ Medicaid/DHS Authorization. DHS 1145 (Hysterectomy) / DHS 1146 (Sterilization)
- ■ Surgery Requisition ■ Pre-Reg Form ■ Copy of Medical Cards

√ = for items present/complete
~~0~~ = for items not present/complete

1	2	3	**Consent**: all must be complete
			Date of Procedure
			Condition
			Medical Language
			Ordinary Language
			Procedure
			Medical Language
			Ordinary Language
			Patient Signature <30 days
			Date ☐ (NO preprinted date)
			Time ☐ (NO preprinted date)
			Witness Signature <30 days
			Date ☐ (NO preprinted date)
			Time ☐ (NO preprinted date)
			Physician Signature <30 days
			Date ☐ (NO preprinted date)
			Time ☐ (NO preprinted date)
			Physician and Patient must date and time their own signature

√ = for items present/complete
~~0~~ = for items not present/complete

1	2	3	**History and Physical:** all must be complete
			< 30 days
			Completed by Physician/PA/APRN with privileges.
			Chief complaint
			Present Illness
			Past Medical History
			Medications
			Allergy History
			Family History
			Social History
			System Review
			Physical Exam
			Impression or Problem List
			Plan or Program
			Dictated in EMR (ASU to print)

1	2	3	**Orders:**
			"Admit to Short Stay" or " Admit Acute Inpatient" **REQUIRED**
			"Discharge" or "Discharge when Short Stay Criteria met" -may be entered after procedure
			Orders dated and signed by physician
			Orders have been entered into EMR by:_____

Pre-op/Pre-procedure Testing:

	Ordered 1	2	3	Included 1	2	3
CBC						
Chemistry						
PT/PTT						
HCG						
Type and Screen						
EKG						
Chest X-ray						
ECHO						

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Checklist Completed By:	Initial	Date
1. Doctor Office		
2. HMC Clerk/Other		
3. HMC RN		