

EN ONLY

Spinal Injection Order

Fax order and information to: 336-328-4415

➤ **REQUIRED**

* Please arrive @ _____ for Registration

Your appt. date is: _____

Your appt. time is: _____

To schedule call (336) 328-3333 Menu option #7
Mon-Thur 7:30am - 6:00pm, Fri 7:30am-5:00pm

ast	First	Middle	➤ Pt. D.O.B.	➤ Practitioner Signature	➤ Date:
			Pt. Sex M or F	➤ Print Name of Practitioner	➤ Time:

on for Exam: _____

0 Code: _____

√ Exam	√ Series of three, only if indicated (x3) injections	CPT(s)	√ Exam	CPT(s)
Lumbar/Sacro ESI (x1)	(x3) injections	62323	Facet Injection	64493
Thoracic/Cervical ESI (x1)	(x3) injections	62321	Sacroiliac Joint Injection <input type="checkbox"/> R <input type="checkbox"/> L	27096

Pre-Authorization required: YES Authorization number _____ Not required

ALLERGIES: _____ NKDA

(If the patient is allergic to IV Contrast, they will need to be pre-treated prior to procedure)

Previous exams and where performed: X-RAY CT MRI _____

Please hold medication(s)/anticoagulant(s) as follows: (MUST BE CLEARED BY PRESCRIBING PRACTITIONER)

<input type="checkbox"/> clopidogrel Bisulfate (Plavix®): 5 days	<input type="checkbox"/> prasugrel (Effient®): 7 days	<input type="checkbox"/> apixaban (Eliquis®): 48 hours
<input type="checkbox"/> fondaparinux (Arixtra®): 4 days	<input type="checkbox"/> rivaroxaban (Xarelto®): 1day	<input type="checkbox"/> enoxaparin(Lovenox®): 1 dose
<input type="checkbox"/> warfarin(Coumadin®/Jantoven®):4 days	<input type="checkbox"/> dabigatran(Pradaxa®):2days	<input type="checkbox"/> edoxaban(Savaysa®): 1 day
<input type="checkbox"/> dipyridamole/aspirin (Aggrenox®):3 days <input type="checkbox"/> aspirin 81mg or greater:3 days		
<input type="checkbox"/> (other)		

Labs: STAT PT/INR (patient on warfarin (Coumadin®/Jantoven®) Other _____

Office Contact Person _____ ext. _____

Phone _____ Fax _____

Please inform us by checking box: Patient is Diabetic, Pregnant, or has Special Needs (please specify)

If you or the patient has any questions before the procedure, please call (336)328-3966, RN in Interventional Radiology.

Please fax this signed order form, imaging reports, especially MRI reports (if not done at Randolph Health), patient's medication list (to include allergies), office notes and history and physical that was completed within **30 days** to (336)328-4415. If this order is for an ESI Series, the patient may call scheduling to schedule their 2nd and 3rd injections.

All Orders must be received within 24 hours prior to the procedure or the patient will have to be rescheduled.

Patient Education:

- Following procedure, the patient CAN NOT DRIVE for the rest of the day. They MUST have a driver to take them home and for the rest of the day.
- Nothing to eat or drink 3 hours prior to procedure.
- Someone will need to be with patient at home for 24 hours after the procedure.
- The procedure will take approximately 30 minutes, but total time at the hospital may be greater than 1 hour.
- Diabetic patients may notice a temporary increase in blood glucose/sugar levels and should check their levels once daily or more often as directed by their physician for the following week.

For performing practitioner: IV Saline Lock, only. Moderate Sedation

Additional Orders: _____



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Spinal Injection Physician Orders
Revised 3-8-23

PATIENT STICKER

