



PORT PLACEMENT

PATIENT:

DOB:

PROCEDURE DATE:

SPOKE TO:

CONTACT#:

ORDERS

- H & P
- DEMOGRAPHICS
- INSURANCE
- MEDS LIST

BLOOD THINNERS:

- ASPIRIN_____MG
- PLAVIX/COUMADIN/WARFARIN_____MG
- IBUPROFEN/MOTRIN/ADVIL

DC DATE: _____ **LAB DATE:** _____

LABS: (CBC, PT, PTT)

WHERE DRAWN:

SENT TO:

- NOTHING TO EAT OR DRINK 8 HOURS PRIOR TO PROCEDURE
- DRIVER/TRANSPORT
- PATIENT SPEAKS ENGLISH: YES/NO IF NO, PERSON TO ACCOMPANY: _____



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