LSUHSC Shreveport
Radiology Department
Proc 15.14.1

Pre Angiography Assessment Form

Patient Name:________________________ Age______Date______Time____

Medical Record#:_____________________Pregnancy:Yes_____No______

Room#:________Is patient taking ASA or anticoagulants Yes_____No_____

Study to be done:______________________________

Reason for exam:______________________________

Name of calling physician, nurse, etc. & beeper#____________________

Name of attending & beeper#:_________________________

Admitting service:____________________

Is patient able to consent? Yes__________ No__________

Labs done: CBC___________ Chem7_________ PT/PTT________

Date Scheduled____________________

Spec Proc MD/RN/RT obtaining information:________________________

Note:____

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