



Rutland Regional Medical Center
 160 Allen Street, Rutland, VT 05701
 Diagnostic Imaging Department
 Phone 747-1755, Fax: 802-747-6200

(Patient Sticker)

IVP/VENOGRAM REFERRAL FORM

Name: _____ DOB: _____ Patient's weight: _____

Date IVP Scheduled: _____ MRN #: _____ Ordering Physician: _____

Reason for Exam: _____

Allergy history: _____

Is patient allergic to the x-ray dye? YES NO

If YES, please explain: _____

Pregnant? YES NO Diabetic? YES NO

★ Glucophage, Metformin, Glucovance, Metaglip, Avandamet? YES NO

Last dose? _____

Instructions given per Metformin policy Patient verbalizes understanding

Prior pertinent surgery _____

BUN _____ CREATININE _____ DATE _____

Advised for diabetics and patients over 60 yrs of age.

FOR DI STAFF USE ONLY

TIME/INITIALS: _____

Date/Time IV start: _____

Device/Location: _____

Pre-medication: _____

Signature/Initials: _____

Amount/Type of contrast: _____

Date/Time IV D/C: _____

Site: Redness? YES NO Edema? YES NO

Signature/Initials: _____

TYPE OF IV PROTOCOL DESIRED

____ Protocol 1

____ Protocol 2

____ Protocol 3

____ ER Protocol

★ Patients taking Glucophage, Metformin, Glucovance, Metaglip, or Avandamet must hold medication for at least 48 hours post exam. Patient requires stable BUN & creatinine prior to restarting Metformin-based medication.