



# SCOPE OF SERVICES

*Radiology*

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Last Name	First Name	Middle Name
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<b>Interventional Procedures</b>	
Angiography	Thrombolysis
Coronary	AV Fistula Graft
Cerebral	Intracranial
Renal	IVC Filters
Pulmonary	PICC Lines
Drainages	Venous & Arterial Stents
Transluminal Angioplasty: Arteries	Biliary Tubes & Drainages
Transluminal Angioplasty: Veins	Nephrostomy tubes and drainage
TIPPS	Cholangiography
Embolization: GI	Stent Graphs
GI	Discogram
Tumor	Vertebroplasty
Uterine	Kyphoplasty
Venous Ablation	Discogram

**Signing below indicates that I am qualified to perform the services chosen on the checklist**

Signature
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Date
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