Interventional & Vascular Consultants, PC

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INTERVENTIONAL RADIOLOGY REFERRAL

Reason for Referral:

- ❑ Peripheral Vascular Disease/Claudication
- ❑ Abdominal Aortic Aneurysm
- ❑ Mesenteric Ischemia/Renovascular Hypertension
- ❑ Varicose Veins
- ❑ DVT Thrombolysis
- ❑ Venous access – Port/other
- ❑ Uterine Fibroids/Uterine Artery Embolization
- ❑ Pelvic Congestion
- ❑ Vertebral Compression Fracture/Kyphoplasty
- ❑ Biopsy: _____
- ❑ Other: _____

Referring Physician: _____

Address: _____

Telephone: _____ **Fax:** _____

Office contact: _____ **Phone:** _____

Patient Information:

Name of Patient: _____

Sex: ❑ Female ❑ Male Birth date: _____ Best contact #: _____

Insurance: _____

Is the patient on blood thinners? ❑ Pradaxa ❑ Coumadin/Warfarin ❑ Aspirin ❑ Other

Has patient had previous imaging? ❑ Yes ❑ No

If yes, where? ❑ Legacy ❑ Providence ❑ Other: _____

Please fax the following information with this request to **503-459-0521:**

- ❑ Demographics
- ❑ History and Physical
- ❑ Copy of Insurance Card
- ❑ Medication List
- ❑ Diagnostic imaging

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