Interventional & Vascular Consultants, PC

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
- ☐ Copy of Insurance card
- ☐ Diagnostic imaging
- ☐ History and Physical
- ☐ Medication List

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