Interventional Radiology Referral Form

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STAT requests call: 727-767-3596
Fax requests to: 727-767-2326

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____ Phone #: _____

Patient Weight: _____ KG Allergies: _____

Diagnosis/Reason for referral**:** _____

Does this procedure require anesthesia? ☐ Yes ☐ No

Labs or special requests: _____

SERVICES REQUESTED

☐ Ablation: _____
☐ Abscess drainage: _____
☐ Angiogram: _____
☐ Arthrocentesis (specify joint(s)): _____
☐ Arthrogram (joint and modality): _____
☐ Biopsy (Core/FNA): _____
☐ Botox injections: _____
☐ Chest tube: _____
☐ Cholecystostomy tube
☐ Dialysis access management
☐ DVT/PE evaluation/management
☐ Endovenous laser ablation therapy (KTS)
☐ Epidural blood patch
☐ Foreign body retrieval
☐ Gastrostomy/GJ tube: _____
☐ Pulmonary AVM embolization
☐ IVC filter: _____
☐ Lumbar Puncture: _____
☐ Lymphangiogram: _____
☐ Mediport/CVAD evaluation: _____
☐ Nephrostomy tube: _____
☐ Nerve block: _____
☐ Neurointervention: _____
☐ Paracentesis
☐ Percutaneous cholangiography (PTC)
PICC (specify # lumens): _____
☐ Portal vein intervention
☐ Renovascular hypertension evaluation
☐ Sclerotherapy: _____
☐ Steroid injection of (specify dose and joint(s): _____
☐ Thoracentesis
☐ Suprapubic catheter
☐ Tunneled catheter placement
(type/location): _____
☐ Transjugular liver biopsy
☐ Transjugular portosystemic shunt (TIPSS)
☐ Transarterial tumor embolization
☐ Ureteral Stent
☐ Varicocele Embolization
☐ Venous hormone sampling: _____
☐ Venogram: _____

Clinical referral:
☐ General IR clinic
☐ Vascular anomalies

Additional details:
_____
_____
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_____

Requesting Physician / Practice Group

Physician Name (print): _____ Direct #: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Ordering Physician Signature: _____ Date: _____