Interventional Radiology Referral Form

Danial Mir M.D.

STAT requests call: 727-284-3128
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: _________________

- Opening Pressures____________
- Closing Pressures_____________

☐ Lymphangiogram: _________________

☐ Mediport/CVAD evaluation: __________
☐ Nephrostomy tube: ________________
☐ Nerve block: ______________________
☐ 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: ______________________

☐ Neurointervention: ______________
☐ Paracentesis
☐ Percutaneous cholangiography (PTC)

PICC (specify # lumens): ____________

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: __________