



Interventional Oncology Referral Form

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone: _____

Patient Insurance: _____

Referring Physician: _____

Phone Number: _____

Fax Number: _____

Prior Imaging: _____

IMAGE GUIDED ASPIRATION

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Thoracentesis | <input type="checkbox"/> Paracentesis | |
| <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> IR Discretion |
| <input type="checkbox"/> Diagnostic | | |

IMAGE GUIDED BIOPSY

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Specific |
| <input type="checkbox"/> Lymph Node | Location(s) _____ |
| <input type="checkbox"/> Bone Marrow | |

INTERVENTIONAL ONCOLOGY CONSULTATION

- Lesion Location(s) _____
- Embolization (bland, chemoembolization/TACE)

VENOUS ACCESS

- | | |
|---|---|
| <input type="checkbox"/> Mediport placement | <input type="checkbox"/> Tunneled central venous catheter |
| <input type="checkbox"/> Mediport Removal | |

OTHER PROCEDURES

- | | |
|--|---|
| <input type="checkbox"/> Tunneled peritoneal catheter | <input type="checkbox"/> Venogram |
| <input type="checkbox"/> Tunneled pleural catheter | <input type="checkbox"/> DVT Evaluation |
| <input type="checkbox"/> IVC filter evaluation / placement | |

Please Attach Patient:

Demographic Sheet, Recent H&P, Diagnostic Images, Labs (including coagulation), Medication List, Insurance Information

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Thank You For The Opportunity To Participate In Your Patient's Health Care