WVU Medicine

Interventional Radiology Referral

PHONE: **304-598-4051** FAX: **304-598-4996**

Date of Referral: _____/_____/_____

Referring Physician: _____

Phone #: _____ Fax #: _____

Signature: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

Gender: **M** **F** DOB: _____/_____/_____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

REASON FOR REFERRAL

Arterial Disease
- ☐ Leg pain / claudication
- ☐ Critical Limb Ischemia
- ☐ Mesenteric Ischemia

Women's Health
- ☐ Uterine Fibroid Embolization
- ☐ Pelvic Congestion Syndrome

Vein Disease
- ☐ Varicose veins
- ☐ Venous ulcer
- ☐ Deep Venous Thrombosis

Oncology
- ☐ Ablation kidney & liver cancer
- ☐ Chemoembolization liver cancer
- ☐ Y-90 embolization liver cancer

Men's Health
- ☐ Varicocele Embolization

Kyphoplasty
- ☐ Compression fracture

GI
- ☐ TIPS

ADDITIONAL HISTORY

PLEASE FAX MOST RECENT CLINIC NOTE, IMAGING REPORTS, DEMOGRAPHICS, INSURANCE CARD, MEDICATION LIST, AND ANTICOAGULATION STOP ORDERS.