Legacy Salmon Creek Medical Center

INTERVENTIONAL RADIOLOGY REFERRAL FORM

Form Updated 1-2021. Please use this referral form for Radia IR referrals.

2211 NE 136th Street
Vancouver, WA 98686
Phone: (360) 487-1800 Fax: (360) 487-1822

Reason for Referral: (Check boxes)

CPT Code for Procedure Requested: _____ ICD 10 code: _____

- ❑ Biliary drainage and stenting
- ❑ Cancer diagnosis and treatments
  - ❑ Biopsy
  - ❑ Cryoablation/Radiofrequency ablation (RFA)
  - ❑ Chemoembolization
  - ❑ Intra-arterial cancer treatment
  - ❑ Pain management/nerve blocks
- ❑ Deep Vein Thrombosis (DVT) treatment
- ❑ Endobiliary intervention
- ❑ Peripheral Vascular Disease diagnosis and treatment
- ❑ Transjugular intrahepatic portosystemic shunt (TIPS)
- ❑ Uterine fibroid/artery embolization
- ❑ Venous access/Ports/Central line
- ❑ Vertebral body augmentation (Kyphoplasty)
- ❑ Image Guided Biopsy: _____
- ❑ Other: _____

Referring Physician Information:

Ordering Physician:_____

Clinic Name:_____

Telephone:_____ Fax:_____

Office contact:_____ Phone:_____

Patient Information:

Name of Patient:_____

Sex: ❑ Female ❑ Male Date of Birth: _____ Best contact #: _____

Insurance: _____ **Authorization Number:**_____

Is the patient on blood thinners? ❑ Pradaxa ❑ Coumadin/Warfarin ❑ Aspirin ❑ Other

Has patient had previous imaging? ❑ Yes ❑ No

If yes, where? ❑ Legacy ❑ PeaceHealth ❑ Other: _____ ❑ Image Date:_____

Please fax the following information with this request to 360-487-1822:

❑ Demographics ❑ Copy of Insurance Card ❑ Diagnostic imaging ❑ History and Physical ❑ Medication List

LEGACY HEALTH

RADIA