# RADIOLOGY REFERRAL FORM: INTERVENTIONAL RADIOLOGY AND NEUROINTERVENTIONAL RADIOLOGY

TRA MEDICAL IMAGING

Phone: 253-284-0841 | Fax: 253-284-0847

## Appointment

Date: _____ Time: _____ ❑ Call patient to schedule ❑ Patient will call to schedule

## Patient Information

Date: _____ Referring Provider: _____

Patient Name: _____ D.O.B.: _____

Phone: _____ Interpreter Needed (language): _____

Height: _____ Weight: _____ Pregnant: ❑ Yes ❑ No Allergies: _____

## Clinic History (signs and symptoms REQUIRED)

Signs/Symptoms: _____

Duration: _____ Area: _____

Cause (Hx, Trauma, etc.): _____

Is this due to an injury? ❑ Yes ❑ No If yes, specify: ❑ MVA ❑ L&I ❑ DOI: _____

## Prior Exams

Date: _____ Facility Location: _____

Date: _____ Facility Location: _____

## Report

Call STAT: (_____) _____ - _____

Fax STAT: (_____) _____ - _____

Fax Routine: (_____) _____ - _____

Additional Report to: _____

## Images

❑ CD ROM

❑ Web PACS

❑ PACS

❑ Deliver to my office

❑ Send with patient

## Insurance Information *(Send copy of patient's insurance card when faxing this referral)*

Insurance(s): _____

Claim # (if applicable): _____

Pre-Authorization #: _____

## INTERVENTIONAL PROCEDURES

### IV Access

❑ Catheter/Port Injection
❑ Catheter/Port Removal
❑ PICC Line Placement
❑ Port Placement
❑ Tunneled Central Catheter (TCC) Placement
❑ Tunneled Dialysis Access Catheter (Permacath, TDAC) Placement

### Drainage and Tube Management

❑ Abscess Drain Placement
❑ Chest Tube Placement
❑ Drainage Catheter Exchange
❑ Drain Removal
❑ Gastrostomy and Gastrojejunostomy Placement/Maintenance/Exchange/ Removal
❑ PleurX Catheter Placement
❑ Other

### Aspiration

❑ Paracentesis
❑ Thoracentesis
❑ Lumbar Puncture
❑ Other Fluid Aspiration

### Bone and Joint Pain Management

❑ Arthrograms
❑ Joint Aspiration
❑ Steroid Injection
❑ SI Joint Injection
❑ Other:

### Spinal Intervention

❑ Epidural Injections
❑ Diagnostic Facet Injection
❑ Therapeutic Facet Injection
❑ Vertebral Augmentation (Vertebroplasty, Kyphoplasty) Consult
❑ Lumbar Puncture
❑ Myelogram
❑ Low Back Pain Consult

### Biopsy, Interventional Oncology

❑ CT Guided Biopsy (Lung, Liver, Renal, Lymph Node, Bone, Bone Marrow)
❑ Ultrasound Guided Biopsy (Thyroid, Liver, Renal, Lymph Node)
❑ Tumor Therapy Consultation (tumor ablation, chemo embo, Y90)

### Women's Health

❑ Fallopian Tube Recanalization Consult
❑ Hysterosalpingogram
❑ UFE Consult
❑ Gonadal Vein Embo Consult

### Arterial and Venous Intervention

❑ Arteriogram Consult
❑ Angioplasty Stenting Consult
❑ Dialysis Fistulagram/Treatment
❑ IVC (Inferior Vena Cava) Filter Placement Consult
❑ IVC (Inferior Vena Cava) Filter Removal Consult
❑ TIPS (Transjugular Intrahepatic Portalsystemic Shunt) Consult
❑ Varicose Vein Therapy (Vein Ablation, Sclerotherapy) Consult
❑ Venous Sclerotherapy

### NeuroInterventional Procedures

❑ Consultation: _____

**Referring Provider Signature** (Required for exam) → _____