NAADI Healthcare
Vascular and Interventional Specialists

Interventional Oncology Referral Form

Patient Name: _____ **DOB:**_____

Patient Address:_____

_____

Patient Phone: _____

Patient Insurance: _____

Referring Physician: _____

Phone Number: _____

Fax Number: _____

Prior Imaging:_____

IMAGE GUIDED ASPIRATION

- ☐ Diagnostic
- ☐ Therapeutic
- ☐ Left
- ☐ Paracentesis
- ☐ Right
- ☐ IR Discretion
- ☐ Thoracentesis

IMAGE GUIDED BIOPSY

- ☐ Liver
- ☐ Kidney
- ☐ Lymph Node
- ☐ Bone Marrow
- ☐ Specific Location(s)_____

INTERVENTIONAL ONCOLOGY CONSULTATION

- ☐ Lesion Location(s)_____
- ☐ Embolization (bland, chemoembolization)
- ☐ RF Ablation for Bone Tumor

VENOUS ACCESS

- ☐ Mediport placement
- ☐ Mediport Removal
- ☐ Tunneled central venous catheter

OTHER PROCEDURES

- ☐ Intrathecal Chemotherapy
- ☐ Tunneled peritoneal catheter
- ☐ Tunneled pleural catheter
- ☐ IVC filter evaluation / placement
- ☐ Venogram
- ☐ DVT Evaluation

PLEASE ATTACH PATIENT:
DEMOGRAPHIC SHEET, RECENT H&P, DIAGNOSTIC IMAGES, LABS (INCLUDING COAGULATION), MEDICATION LIST, INSURANCE CARDS

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